

DUPLICATE

December 1959

Resident Physician

JOURNAL FOR THE HOSPITAL STAFF OFFICER

I CHOSE
ACADEMIC MEDICINE

ARE RESIDENTS
DOING GHOST SURGERY?

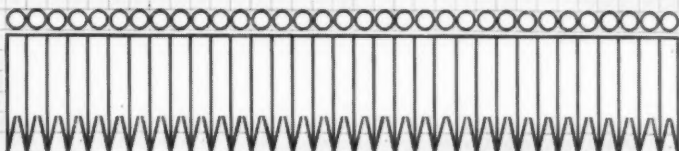


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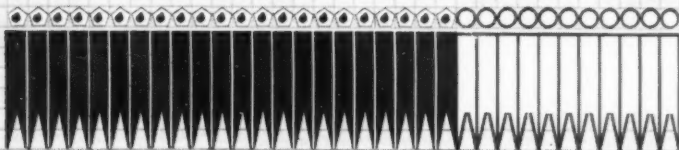
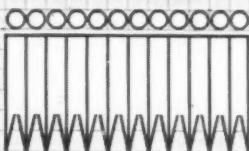
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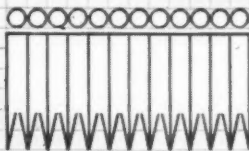
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2. Bunin, J.J., et al.: Paper read before the Am. Rheum.
Assoc., San Francisco, Calif., June 21, 1958.

*Cortisone, prednisone and prednisolone.

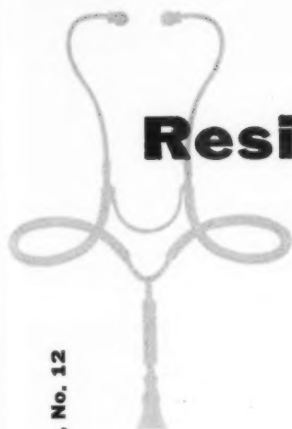
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Resident Physician

December 1959, Vol. 5, No. 12

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"Estrogen treatment is quite specific for the vasomotor and most of the other symptoms of the typical menopausal syndrome."

Rakoff, A.E., in Goldzieher, M.A., and Goldzieher, J.W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, chap. 23, p. 345.

The vasomotor symptoms such as hot flushes and palpitations are readily identified with the menopausal syndrome, and related to declining ovarian secretion. Not so the multiplicity of other symptoms which may appear long before, or even years after, menstruation ceases, such as headache, insomnia, irritability and fatigability; and the musculoskeletal symptoms ranging from vague pains, arthralgias and myalgias to postmenopausal osteoporosis. In either case, the cause is the same: estrogen deficiency.

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Estrogen replacement therapy specifically treats the basic deficiency. It stabilizes the vasomotor system enabling the patient to readjust to a new physiologic environment. Furthermore, estrogen is not just a "female sex hormone." It has a beneficial effect on bone and on protein metabolism;¹ on uterine supporting structures;² on the skin, and the mucosa—not only of the vaginal tract but also of the urinary bladder and stomach.³⁻⁵ Estrogen provides a possible relative immunity to coronary atherosclerosis,⁶ and helps to counterbalance the tendency to adrenal and pituitary hyperactivity.⁷

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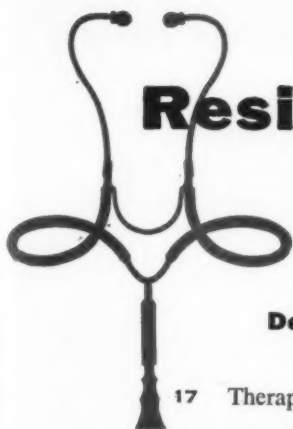
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10. Randall, C.L., Birch, P.K., and Harkins, J.L.: *Am. J. Obst. & Gynec.* 74:719 (Oct.) 1957.

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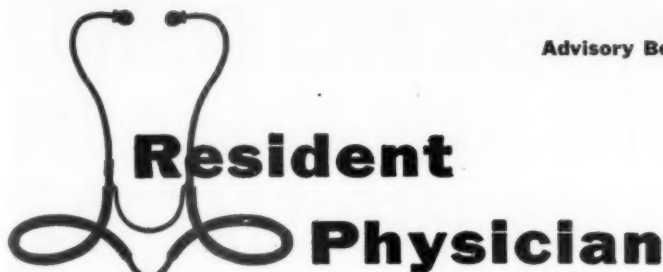
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J. L.: J. Am. Pharm. Assn.
(Scient. Ed.) 39:21 (Jan.) 1950.

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J. Am. Med. Assn. 158:388
(June 4) 1955.

3

Tebrock, H. E.: Ind. Med. & Surg.
20:480-492, 1951.

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Therapeutic Reference

The following index contains all the products advertised in this issue. Each product has been listed under the heading describing its major function. By referring to the pages listed, the reader can obtain more complete information. All products are registered trademarks, except those with an asterisk(*).

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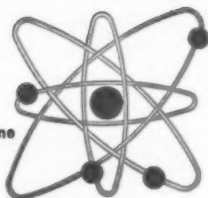
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Edited by Maxwell H. Poppel, M.D., F.A.C.R.,
Professor of Radiology, New York University College of Medicine
and Director of Radiology, Bellevue Hospital Center

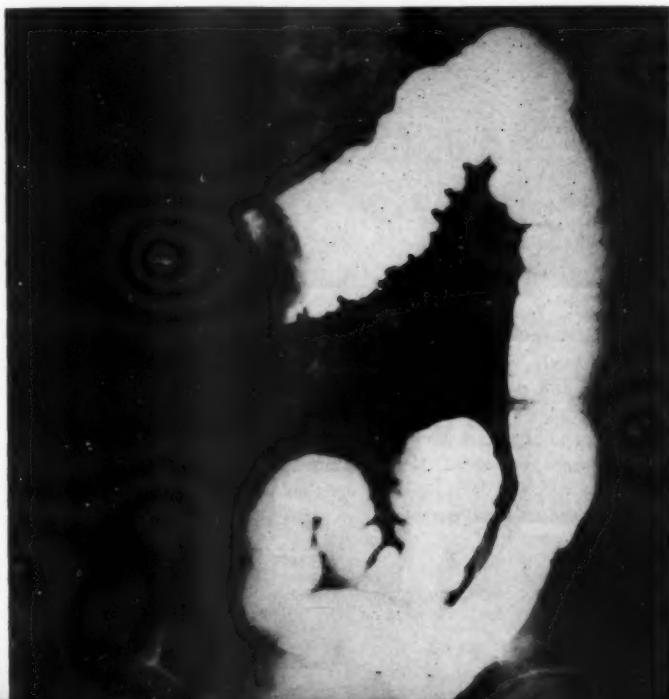


Sixty-three-year-old male. Chief complaint — Colicky abdominal pain of 3 weeks' duration. Relieved by passing gas.

Which is your diagnosis?

1. Ca of transverse colon
2. Intussuscepting lipoma in transverse colon
3. Polyp in transverse colon
4. Ileo-colic intussusception

(Answer on page 171)



anorectal comfort in minutes



Anusol-HC

dependable Anusol Hemorrhoidal Suppositories with hydrocortisone (10 mg.)

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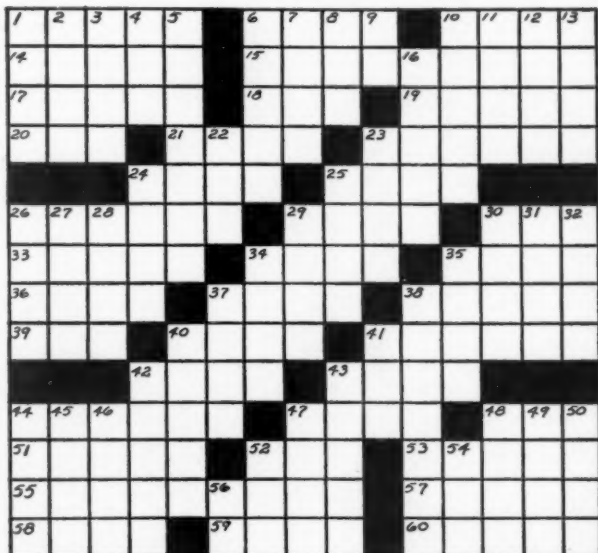
1. Schleich's paste
6. Bone instrument
10. Visitors are — in sick room
4. States positively
5. Common joint disease
7. Projecting growth from a mucus surface
8. English physician (1819-1900)
9. Make amends
10. Pointed tool
11. An article
13. Covered with a thin layer
14. Part of the eye
5. Corn meal bread
6. Produced by putrefaction
9. Inter
10. Kind of balm
3. Another time
4. Metal used in dentistry
5. Tissue
6. Pike-like fish
7. Minim
8. Infectious agent
9. Poem
10. Blood vessel
1. Vibrate
2. Fine sand
3. Obligation
4. Specimen of blood for analysis
7. Ray emitted by radium
8. Our mutual Uncle
1. Standard of perfection
2. "—" applications are good for 15 Across
3. Cut into small pieces
5. Drug used in 15 Across
7. Angry
8. Joint
9. German river
10. Time when diseases seem worse

DOWN

1. Verine, opium derivative
2. Declare openly
3. Barter
4. Attempt
5. Anodyne
6. Violent passions
7. Plant furnishing sago
8. Hordeolum

Resident Relaxer

(Answer on page 171)



9. Pharmacist (Abbr.)
10. Name
11. Small particle
12. Twining plant
13. Employed
16. Unfavorable weather
22. Nervous twitch
23. Wade
24. Inflammation (suffix)
25. Soft tissue
26. Spleen in amyloid disease
27. Old oath
28. Famous French surgeon (1510-1590)
29. What the physician is to humanity
30. Great mass of ice
31. Jewish month
32. Medicine will — pain
34. Unyielding courage
35. Very small
37. Cancel
38. Metabolic catalyst
40. Fat-absorbing parts of the intestine
41. Young pharaoh (abbr.)
42. Flood
43. Turn aside
44. Not in good health
45. Apparatus used to transmit parallel rays
46. Nothing but
47. Ossified tissue
48. Protuberance
49. Pituitary hormone
50. Convene
52. Brick carrier
54. Biblical character
56. Thus

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Letters

to the Editor



*Unsigned letters will neither
be published nor read.*

*However, at your request,
your name will be withheld.*

ECFMG

I accept the theory that the examination of the ECFMG is sound, is right and serves to defend the American public health against poor quality medical care.

It is sponsored by most of the state boards which have made it a prerequisite for eligibility; it is sponsored by the AMA, the American Hospital Association and others.

It is made up of questions used before by the National Board, approved by eminent teachers, and answered previously by hundreds of American graduates.

How is it, then, that an American citizen and foreign graduate who passes it and obtains a medical license is denied reciprocity?

The same State Board which requires it for eligibility denies

reciprocity to the doctor who passed it and has a medical license in another state with which it reciprocates.

The ECFMG examination appears to be an unfair imposition as long as it serves merely to procure a better labor force for American hospitals. And if it is this way, let's say that.

I hope something about this subject can be published and maybe answered by Dr. D. F. Smiley.

I am American. I am a foreign graduate. I passed the above examination and then a state board; but I am now denied reciprocity, and thus I cannot obtain positions in states in which I have good opportunities.
Name withheld at writer's request
Kansas City, Missouri

—Continued on page 40

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I would like to receive details on (1) your financing plan; (2) information regarding your General Catalog; (3) and your article, "What Will I Need To Set Up Practice?"

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—Continued from page 33

Practice, Anyone?

I am in a dilemma. I am calling on you for help in a matter which I think is important and I hope that you will agree.

I have advertised in the classified section of our regional medical journal, and my ad was engulfed by those offering more lucrative positions. The wording of these ads made it obvious to me that those applying would be unsuitable for what is available here. I now turn to you — and present this problem in a somewhat unorthodox manner. However, there must be another individual among the vast training force seeking the same satisfactions that my wife and I were seeking during my general practice residency three years ago.

We wanted to find a rural general practice in which we could be happy serving a community which truly needed medical attention. After slightly more than two years we feel we have been successful in our quest.

The practice is located in a small southern New Hampshire town, 13 miles from the largest city in the state with its excellent hospital and consulting physicians, and less than two hours from Boston, with its unsurpassed

facilities for one day a week continuing postgraduate medical education.

The practice is demanding: A 12-17 mile area radius includes some 12,000-14,000 population among 10 towns, the practices of five excellent physicians and surgeons, none of whom are closer to forty than fifty years of age.

The physician and his family who would be interested in sharing the practice would be one whose chief fear in life is the boredom and complacency and chronic insincerity of conventional "country club life."

Our gross is more than twice what I had anticipated at this stage of the game. Our collection rate is 93% (we just now have gotten statements into the mail for the first time this year.) We have two full time and two part time aides in the office. We do x-ray, EKG, an expanding lab to do screening chemistries — and two Dalmatians to add to the general confusion. This, plus a burning desire to find someone who feels as we do, in order that we may offer the increasing number of patients the same 'family physician' medical care we believe in. I do no surgery that cannot be done in the office; consultants are called in to the extent

—Continued on page 46

EVEN IN "SEEMINGLY HOPELESS CASES" INVOLVING "HOSPITAL STAPH" ...

ALBAMYCIN*

"It would appear, therefore, that from this limited experience with 17 desperately ill patients, parenteral novobiocin [Albamylin] is therapeutically effective and offers a reasonable expectation of a favorable response even in seemingly hopeless cases."

Garry, M. W.: *Am. J. M. Sc.* 236:330 (Sept.) 1958.

"Staphylococcal sepsis, particularly as it appears within the hospital environment, continues to represent a serious and difficult therapeutic problem. . . . It would appear that novobiocin [Albamylin],

like other broad-spectrum antimicrobial agents, will be of clinical value in a certain number of staphylococcal infections."

Colville, J. M.; Gale, H. H.; Cox, F., and Quinn, E. L.: *Antibiotics Annual 1957-1958*, p. 920.

The use of Albamylin has not been accompanied by systemic toxicity—renal, hepatic, or hematopoietic. Side effects (such as skin rash) have been minor in nature, and those that do occur are easily managed.¹⁻³

1. Garry, M. W., *op. cit.* 2. Editorial, *New England J. Med.* 261:132 (July 16) 1959. 3. Nunn, D. B., and Parker, E. F.: *Am. Surgeon* 24:361 (May) 1958.



*TRADEMARK, REG. U. S. PAT. OFF.—THE UPJOHN BRAND OF CRYSTALLINE NOVOBIOCIN SODIUM

The Upjohn Company
Kalamazoo, Michigan

Upjohn

—Continued from page 40

that an internist and obstetrician cover for me when I am in Boston for classes and also when we try to take a day off.

Our physical and mental stamina have been challenged by the rate of growth of the practice. I realize that there are times when a short cut is attempted in obtaining a history on apparently functional patients. I thank God a pelvic was done the other night on a 34-year-old-women who came in complaining of nervousness, and turned out to have a

grade 3 squamous cell carcinoma of the cervix.

If there is another young physician—with family or not—who will tolerate the life we lead and who could derive satisfaction from the somewhat selfish motive of knowing they are giving the people in the area the benefit of more scientific, more thorough therapeutic and preventive medical care than the general population has ever known — then, please let them get in touch so that we may have them visit our area and let them see for them-

—Concluded on page 50



quieting...calming

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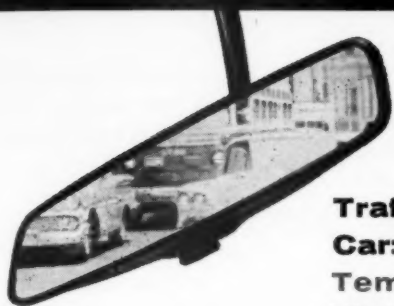
...has a gently controlling effect on blood pressure and tension, without unpleasant side effects.

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Traffic: jammed
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Here's a man whose ulcer once would have protested strongly—not just at traffic problems—but at the entire gamut of stress to which modern man is subjected.

His physician, aware that *the patient as well as the ulcer* must be treated, has prescribed ALUDROX SA.

eases tension • promotes healing
relieves pain • reduces acid secretion
inhibits gastric motility

ALUDROX[®] SA

Suspension and Tablets: Aluminum Hydroxide Gel with Magnesium Hydroxide, Ambutonium Bromide and Butabarbital, Wyeth



Philadelphia 1, Pa.

—Concluded from page 46

selves if this is not the manner in which to best invest their talents.

Thomas G. Abell, M.D.

Raymond,
New Hampshire

Chief Resident Series

Interns and residents should be very happy to receive a medical magazine such as *Resident Physician* . . .

The regular monthly features Mediquiz, Viewbox Diagnosis, Letters to the Editor, Leads and Needs, have always been of great interest. . . . But the main reason for my letter is to congratulate you on the originality and interest of the article, "Chief Resident Symposium." It created such interest among interns, residents, and even the attending and directing staffs that perhaps all of them would appreciate very much if these articles were extended to include other leading teaching centers and other departments such as internal medicine, pediatrics, obstetrics, pathology, radiology, etc.

Elio F. Vieira, M.D.

Chief Resident, Radiology
Metropolitan Hospital
New York Medical College-
Metropolitan Medical Center
New York City, New York

• *Four specialty services are included in our current series: internal medicine, surgery, pediatrics and Ob-Gyn.*

Swedish Medicine

Would the *Resident Physician* be interested in an article or series of articles on Swedish medicine, training and the medical-social welfare system?

I am an American, graduate of an American medical school, and am currently taking a residency in pediatrics at Karolinska Hospital in Stockholm.

George Contis, M.D.
Sundbyberg, Sweden

• *We would appreciate having an opportunity to see your article. At present we are compiling a series of brief profiles of the medical systems in various foreign countries and plan to begin publishing these soon.*

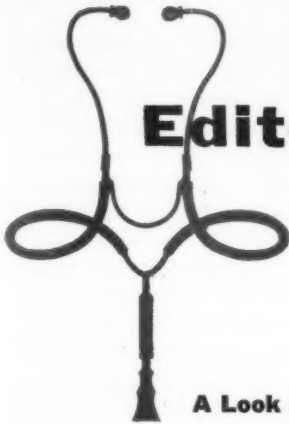
Reading

I enjoyed very much the article by Amos R. Koontz, M.D. entitled "Reading for Young Doctors" which appeared in the September issue of *Resident Physician*.

I would very much like a reprint of this article. Enclosed find 15c.

George D. Manstra, M.D.
Grand Rapids, Michigan

Perrin H. Long, M.D.



Editor's Page

A Look at the Future?

Over a dateline of September 20th, the *New York Times* carried the following headline:

"UNIONS IN CITY PLAN CHAIN OF HOSPITALS OF THEIR OWN."

The article went on to say that "Labor in New York has set up formal machinery to consider building its own hospital chain and operating its own medical system in competition with Blue Cross and Blue Shield."

Why do this? Because it is the belief of many union leaders that their members "pay too much for too little service" from Blue Cross and Blue Shield programs. Also, to quote from the *Times*, the statement of the president of the New York City Central Labor Council, "We have sweatshop health standards in hospitals." This is an interesting and probably intentional distortion of the English language, because the health standards are extremely high in hospitals in New York City. Everybody agrees that wages should be higher, but then the non-professional employees in these hospitals rarely sweat from work. At least this is true in a number of hospitals with which your Editor is familiar. The statement goes on to say "They (the hospitals)

make no accounting to the public. Yet we are confronted with skyrocketing costs that must be paid out of our welfare funds" (largely contributed by management). "Blue Cross has gone through the motions of providing community representations on its board, but it is a farce. Labor is out-voted 5 to 1. The program is under the control of big business and the hospital administrators. We intend to develop a program which will benefit all people in the city."

After this blast, the president of the Greater New York Hospital Association was quoted in the *Times* relative to Labor's proposal to build a hospital chain as follows: "All I can say is 'Welcome to the Deficit Club.'" This remark makes it clear that he is unfamiliar with or not thinking of the way unions finance their health schemes. The owners carry the load.

What's back of all this? A number of complaints, not only from Labor but also from many non-union subscribers to Blue Cross programs. Blue Cross rates have skyrocketed in the last decade. It is well known that the increases in rates have been approved by the state insurance commissioner because hospital costs have risen. On this point there is room for an argument. Blue Cross has acted solely as a fiscal agent, paying out to well run and poorly run hospitals alike. Many of its subscribers believe Blue Cross should use its great influence to bring about better business practices in its member hospitals in an effort to bring down or stabilize costs. Labor has a valid complaint here.

The statement that hospitals do not make accountings to the public is pure union nonsense. As voluntary hospitals are constantly appealing to the public for money, their fund raising committees are continually putting out elaborate financial statements in their appeal brochures.

The complaint that unions are not represented proportionately on the Board of Blue Cross and Blue Shield deserves careful consideration. According to the most recent figures (*New York Times*, September 27, 1959) Blue Cross

has slightly over seven million subscribers. Labor says that about one million of these subscribers are union members or their dependents. The president of the Teamsters Joint Council No. 16 states in a letter to the *New York Times* of September 29, 1959, "Our local unions have collective bargaining agreements with employers providing hospitalization insurance and other benefits for more than 250,000 employees and their dependents in Greater New York. A sizable proportion of these covered members and their families are insured in Blue Cross." Hence, its complaint about being in a five to one minority on the Board is another distortion. Union members and their dependents make up one-seventh of the membership. Their representation should be one in seven, not one in five. But as usual, nothing will probably satisfy Labor but outright control.

There is little doubt as far as the New York scene is concerned that the hospital strikes of last spring have had some influence in Labor's decision to study setting up its own hospitals. Labor has consistently insisted that wages could be raised without costs of operation (and hence Blue Cross rates) going up proportionately. This has been a bone of continuing contention. What Labor has not suggested is putting a deductible clause, say of seventy-five or one hundred dollars, in each Blue Cross contract to prevent both patients and doctors from misusing Blue Cross for diagnostic work-ups, when hospitalization is not necessary from the point of view of the immediate health of the patient. *The abuse of Blue Cross coverage for paying for diagnostic surveys must be eliminated.*

And finally, as was mentioned earlier, all must understand that unions just don't join "Deficit Clubs" as stated by the president of the Greater New York Hospital Association. When costs go up the union just increases the bite on the employer at the next contract period. As a rule the increased costs are passed on to the consumer. Unions do not have deficits.

Well this is the situation in New York today, and what is being talked about there is being discussed all over this country. So, Doctor, you may be working for a union long before you had ever expected to! The other alternative? Just as bad! The supersedure of Blue Cross by compulsory National Health Insurance partially financed and completely managed by the Federal Government! This has already happened in most of the Canadian provinces.

NATIONAL FOUNDATION FELLOWSHIPS

Fellowships of \$4500 a year for clinical study in arthritis and related diseases are available to physicians interested in rheumatic diseases and who intend to apply their knowledge of these diseases to clinical service, teaching, or research. The National Foundation announced that only physicians licensed or eligible for licensure in the United States and who have had at least two years of specialty training acceptable to the appropriate American Board (or equivalent training) are eligible. All applicants must be citizens of the United States.

The candidate should propose a program of full time study in a hospital—preferably university-affiliated—which offers a well developed program in arthritis and related diseases. The major portion of his time should be spent in clinical service, but a small amount may be devoted to research and teaching. Financial support for the Fellow is \$4500 a year with \$540 allowed annually for each dependent.

Applications must be received by February 1 for consideration May 1, 1960; August 1 for consideration November 1, 1960, and November 1 for February 1, 1961.



Why I Chose Academic Medicine

Each house staff officer must decide which of the many medical roads he will travel. A resident-turned-teacher tells how he made the choice and why.

James A. Knight, B.D., M.D.

The responsibility of the physician to teach his art was first set forth in the fifth century B. C. in the oath of Hippocrates. For almost twenty-five centuries this oath has been the credo of the medical profession. It specifies the relationships of teacher and medical student and binds the physician to teach the art of medicine in the following words:

"... according to my ability and judgment, I will keep this Oath and this stipulation — to reckon him who taught me this Art equally dear to me as my parents, to share my substance with him, and relieve his necessi-

ties if required; to look upon his offspring in the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation; and that by precept, lecture, and every other mode of instruction, I will impart a knowledge of the Art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none others."

At some stage in your training, you'll wrestle with the choice of private practice or an academic career. If you accept the student cliché, that the upper third of a

medical school class make the best teachers, the middle third the best practicing physicians, and the lower third the most money, then you can readily determine your particular category. But if you question that pat formula, then you'll find your decision complicated by conscious and unconscious motivation.

My decision was as simple or as complicated as yours will be.

Discovery

I discovered that in a medical school setting the three functions of medicine—teaching, research, and practice—are blended. Since each faculty member is usually encouraged to participate in all three of these functions, there is variety in each day's activity.

Seeing one patient after another with emotional disorders for five to ten hours each day, as required by a private practice in psychiatry, would soon lose its challenge for me. As one psychiatrist-teacher told me: "In order for a psychiatrist to survive in the kind of isolation imposed by private psychiatric practice, he has to develop almost an omnipotence."

As a faculty member, one's day may include a wide range of activity including lecturing, supervision, seeing patients, and

laboratory or scholarly research.

In choosing faculty members, selection committees place great emphasis upon ability and interest in research. (Possibly too much emphasis is placed upon this single requirement.) There are several reasons for this, among them the availability of research grants which form a substantial part of the medical school budget. Another is the often neglected responsibility of faculty members to produce as well as distribute knowledge.

Research is, however, a broad-based concept and implies much more than investigative work in the laboratory.¹ The development of new ideas, techniques, and approaches growing out of clinical work, is an opportunity every clinician has. Also the combination of his clinical experience with scholarly research in the library can form the basis of useful contributions to medical knowledge.

Clinical training

Mastery of the clinical subjects and ability to teach are also considered in the selection of personnel, and attention paid to the preparation of medical teachers in the art of teaching.

Wherever emphases may be placed, the full-time clinician is

indispensable in medical education. A student may acquire large amounts of information from lectures and books and memorize the technique of its application, but this is not enough to make a physician.

The medical student needs the guidance and supervision of a clinician who helps him to practice and to understand diagnosis, treatment, and prevention of disease and to comprehend the art of medicine and the doctor-patient relationship. I am looking forward to learning in all these respects and to giving my students insight into my learnings.

Success

If one feels the importance of such work he should be able to carve a niche for himself in an academic setting. Also, he should derive comfort from these words spoken by Sir William Osler in 1911, at the opening of the new Pathological Institute of the Royal Infirmary in Glasgow:

"In the hurly-burly of today, when the competition is so keen, and there are so many seeking the bubble reputation at the eye-piece and the test-tube, it is well for young men to remember that no bubble is so iridescent or floats longer than that blown by the successful teacher. A man

who is not fond of students and who does not suffer their foibles gladly, misses the greatest zest in life; and the teacher who wraps himself in the cloak of his researches, and lives apart from the bright spirits of the coming generation, is very apt to find his garment the shirt of Nessus."³

Prior to this, he spoke these memorable words in his farewell address to the Johns Hopkins University in 1905:

*"I desire no other epitaph . . . than the statement that I taught medical students in the wards, as I regard this as by far the most useful and important work I have been called upon to do."*³

It is almost unbelievable that William Osler was the first teacher to introduce bedside teaching for students and to develop clinical clerkships.⁴

Schedule

The academic career enables one to live a more regularly ordered life than does private practice. This is of little consequence to many physicians but to others it is exceedingly important for peace of mind, and even survival. Demands from the public are often less, and these can be partly controlled. In fact, they must be controlled if scheduled teaching and investigative work

are pursued. Yet academic life with demands from teaching, research, and administration can become so hectic that private practice may offer a slower pace.

A psychiatrist in a medical school setting has an excellent opportunity to work with the preventive aspects of psychiatry. One way he does this is through the medical student, in teaching and also treatment, if the opportunity arises. Emotionally healthy medical graduates with a clear concept of what constitutes mental health will multiply the positive influence of their psychiatric teacher many fold.

Also participation by the faculty member in many phases of mental hygiene planning is encouraged and needed. Through the processes of education one generation advances a little beyond its predecessor. It is part of the university medical center's task to translate the product of the contributors to man's knowledge of man into the ways of life

of the multitudes who often lack a conscious belief in the practical helpfulness of advancing science.

Modern insight

Emotional illness often cripples permanently. Since many disorders can be modified or their appearance delayed, it is a tragedy not to make available to the public the meaningful insights of modern day psychiatry. The university medical center seeks to implement the dissemination of such knowledge and its utilization by those many people whose interest in problems of mental health is still dormant and whose belief in the efficacy of recent developments are slim or nonexistent.

The academic environment is stimulating for anyone who has a need to be in the forefront of medical advances. Here it is easier, but by no means effortless, to learn of new approaches and even to be a part of some of these. Often the isolation and

About The Author

Graduating from Vanderbilt University Medical School in 1952, the author interned and took a three year residency in psychiatry at Charity Hospital of Louisiana at New Orleans, Tulane Service. He is currently Assistant Professor of Psychiatry, Baylor University College of Medicine, Texas Medical Center, Houston, Texas.

consuming demands of private practice interfere with study and attendance at conferences and refresher courses.

Teacher

The role of teacher is the phase of academic medicine which offers me the greatest challenge. In my youth the three professional people demanding the greatest respect and admiration from my peers and myself were the teacher, the minister and the physician. Many of us incorporated these heroes as part of our ego-ideal. Such an influence or identification is manifesting itself today in my effort to combine the activities of these three professions.

I have a theological degree and served as a navy chaplain during World War II. While counseling patients and shipmates aboard a hospital ship in the Pacific, I realized the need for more thorough training in understanding human behavior, especially the unconscious determinants. Plans began to take shape then for the study of medicine and later specialization in psychiatry. Baylor University College of Medicine is a favorable setting for my combined interest in both of these disciplines because of its own concern for religious values and

also because next door to it is the Institute of Religion where hospital chaplains are trained. I want to examine the inter-relationships, values, and concerns of psychiatry and religion and see how the distinctions have been sources of creative tension, cooperation, and conflict among ministers and physicians.

Healing

My emphasis upon academic medicine in this article is not to be construed as a depreciation of private practice. The great burden carried by the private practitioner in the healing and prevention of disease earns for him a place of solid acceptance and appreciation in the community where he labors.

Also, the practitioner may stress some of the disadvantages of an academic career. Chief among these is that the financial rewards are less than those that may be had in private practice.⁵ He may challenge the emphasis on writing, "publications would not be burdened with worthless articles if every physician was urged to hold his pen until he could keep silent no longer."

As for research, rarely is an investigator productive all of his life. As had been said jokingly, but with more than an element

of truth, the researcher in the first trimester of his career makes a useful discovery. Then in the second trimester he raises funds to build a new laboratory. In the final trimester of his career he spends his time showing prominent visitors his new and well-equipped laboratory.

Thus, in private practice one would presumably be productive longer, being stimulated by the demands of his patients.

Those who remain in academic settings have been accused of not being able to cut the umbilical cord.

Ideals

I believe that ideals and spiritual values form the foundation of the vocation of medicine. The physician has a mission or calling with a core that tends toward the sacred, that even may be sacred. It is the misfortune of our medical profession that this very core may have been lost in the "materialism" of our era. I am free in this academic community to do my teaching in such a way that students can comprehend the full measure of the vocation of healing. I don't want to be anywhere else as long as such an opportunity exists here.

Since I have used such words as vocation, mission, and calling,

I would like to discuss my concept of vocation. Vocation implies a call. The question immediately asked is—called to what and by whom? The call is from God and it is a call to life. The concept of divine vocation has practically disappeared from present-day thinking.

Divine vocation

Life cannot rightly be broken into segments, and certain experiences called secular and others religious. Religion can and should pervade all of life, for it is a devotion to the whole of life. If religion is thought of in terms of *divine vocation*, all life falls into a different perspective. To think in this manner is to conceive of religion as the calling forth of all of man's capacities and skills into worship and work for the common good of all, by a power greater than himself or the world in which he lives.

The monastic ideal of the medieval Church held up the lives of celibate clergy and the religious as more pleasing to God than the lives of the common people engaged in doing the ordinary work of the world. Certain medieval preachers and mystics, however, applied to these common pursuits an impressive term *Vocatio Dei*, that meant "divine

calling." Luther and Calvin followed and overpassed the lead of these preachers and mystics. The reformers declared that what a man can do with his hands and brain is not within itself pleasing to God, but that all God requires of any man—faith and obedience—can be shown by each person in that place to which the divine will has assigned him. Luther, Calvin, and their like-minded contemporaries set the example for a genuinely new estimate of everyday life and toil. It was a fresh approach toward reassertion of the ancient premise that worship and ordinary work belong together, that the adoration

of God should be integral to everyday life.

Scarcely could these ideas and ideals be more pungently expressed than in a prayer written by St. Augustine in 354 A.D.: *'O Lord, our Saviour, who hast warned us that Thou wilt require much of those to whom much is given; Grant that we, whose lot is cast in so goodly a heritage, may strive together the more abundantly to extend to others what we so richly enjoy. And as we have entered into the labours of other men, so to labour, that, in turn, other men may enter into ours, to the fulfillment of Thy holy will.'*

Notes

1. There are investigators who define rather rigidly what is meant by research, and distinguish sharply between such terms as true investigator, discoverer, rediscoverer, and developer. See Burch, George E.: *On Research People*. New York, Grune and Stratton (1955), Pp. 5-10.


2. Quoted by Cushing, Harvey: *The Life of Sir William Osler*. Oxford, The Clarendon Press (1925), Vol. 2, Pp. 295-296.

3. Osler, William: *Aequanimitas*, ed. 3. Philadelphia, Blakiston Company (1932),

P. 390.

4. Robinson, G. Canby: *Adventures in Medical Education. A Personal Narrative of the Great Advance of American Medicine*. Harvard University Press (1957), Pp. 38, 49-50, 316.

5. The problem on income for teachers is far from being a recent one. A leading citizen of ancient Rome deprecated the fact that actors and gladiators were paid much more than teachers. (*Psychiatry and Medical Education*. Washington, American Psychiatric Association (1952), P. 34.)



Are Residents Doing Ghost

Basic to the residency system of postgraduate education is the opportunity given the resident to obtain practical experience in caring for hospital patients.

In fact, the most important reason for taking residency training, generally at no small investment of time and dollars, is to learn more by doing more—while backstopped by an interested, capable, and available attending staff.

Says one medical educator: "When given responsibility for work-up, diagnosis, ordering tests, choice of therapy, operations and follow-up, the resident advances rapidly. He develops judgment, and with it, confidence. Eventually he may attain board certification of his ability—not simply knowledge—in his special field."

Yet, as a hospital's service patient load declines, where will the resident get "his" patients?

The answer, according to many medical educators, must be found in the private or semiprivate cases.

Does this mean ghost surgery? One surgical chief put it this way. "So-called 'ghost surgery' does undoubtedly occur in rare situations. The

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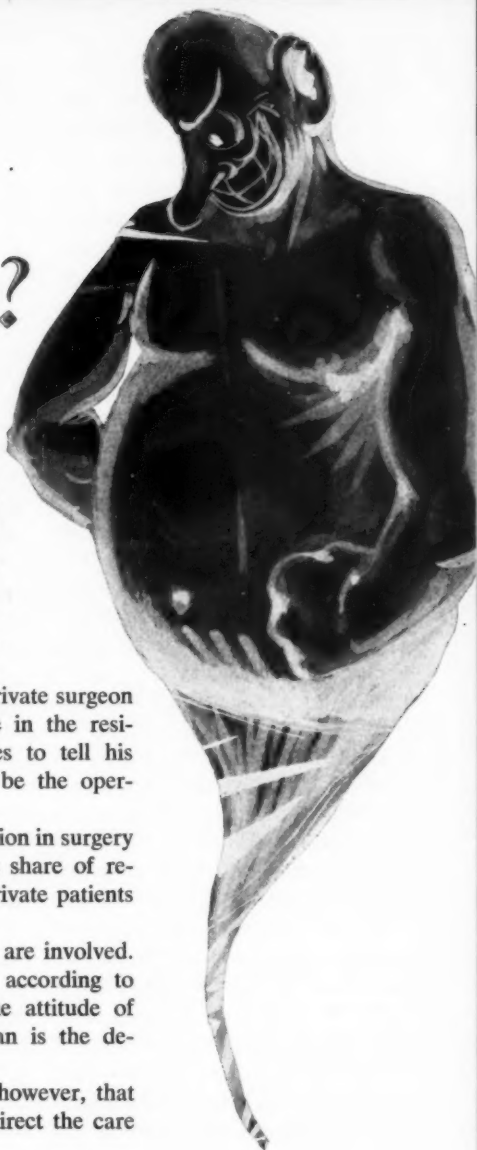
private surgeon 'forgets' to inform the patient that the chief will be the operator. But this does not happen in a good teaching hospital. First of all, if a patient is notified that the resident will be directed in the surgery by the private surgeon, there is seldom a problem.

The odd thing is, though the private surgeon may have absolute confidence in the resident's ability, he still hesitates to tell his patient that the resident will be the operator."

What then is the actual situation in surgery today? What is the resident's share of responsibility in surgery when private patients are involved?

It depends. Many variables are involved. "In a majority of instances," according to one professor of surgery, "the attitude of the individual private physician is the deciding factor."

There's general agreement, however, that the resident's opportunity to direct the care



A squeeze play is on and some residency programs are caught squarely in the middle. Many hospitals are finding it tough to get enough service cases. Reasons? Soaring personal incomes and a boom in medical care plans are gradually thinning the ranks of the medically indigent, traditional ward service patient pool.

of, or perform surgery on private patients is minor compared to his opportunities with service cases.

This is, or was a perfectly logical arrangement. With enough service cases around for teaching purposes, there was no pressing need for attending staff members to put their patients in service beds to further the resident's education. The resident would, on orders, work-up a private patient for the attending—or take over any portion of patient responsibility advanced him by the attending. The attending physician would continue to advise and recommend to the resident concerning his patients.

However, the expansion of medical care plans for the prepayment of medical and surgical bills continues at a dizzy pace.

Coverage includes union plans and fraternal groups; profit and nonprofit. While plans for groups and for individuals are adding new thousands, Congress is expected to consider "catastrophic illness" reinsurance legislation in an early session.

Currently, the percentage of patients able to pay part or all their medical costs, increases month by month.

Become private patients

All this simply means that many patients who previously would have entered hospitals on a service basis, today are covered by some form of medical care insurance. When ill, they seek out a private physician who admits them to the hospital. They become private patients. The surgical resident is being forced out of the picture. Or is he?

Changing situation

There's some indication that the situation is changing. In many hospitals the attending is being asked to share with the resident more responsibility in private patient care, utilizing the private patient for the purpose of training the resident.

Some attendings refuse to go along. In certain hospitals, the dissenting attendings are upheld

by the hospital's administration. In others, the attending may be viewed as "non-cooperative." Action may or may not be taken.

The resident, if he finds the situation intolerable, may finish out his year and move on to another institution. That's no solution for residents in general.

Many hospitals, alert to the dilution of resident responsibility and the resulting loss of value to the resident of his hospital education, have already taken measures to preserve the quality of their teaching programs. These hospitals are convinced that active resident participation improves patient care. The hospitals want to attract capable residents.

One program

Some are, by degrees, patterning their programs after the plan of the University of Chicago Clinics. The Clinics, depending entirely upon private patients for budgetary needs, consider all patients as teaching patients. Dr. Lowell T. Coggeshall, Chairman of the Department of Medicine and Dean of the School Biological Sciences at the University of Chicago, described the plan in a symposium on graduate medical education in the *Journal of Medical Education*.*

" . . . from the outset, every patient admitted to the clinics was utilized for teaching purposes and today is so informed on admission," Dr. Coggeshall reported.

Since the hospital is not equipped with large wards and there is "relatively little difference in accommodations," the resident and attending staff rarely knows "which patient is charity and which is full pay," according to Dr. Coggeshall. He reports further:

"After almost three decades of experience, neither the administration nor the staff would wish it changed, and we look upon the original necessity for using the paying patient for teaching purposes as a fortunate incident rather than a handicap."

Compromise

How about a half-way measure, a compromise plan which would permit the chief of each service to choose the patients the resident would be allowed to care for and those whom he should not? Actually, this plan, with modifications, is in effect today in a number of voluntary hospitals. Its drawback, from the resident's point of view, is that too

* *Journal of Medical Education*, May 1955.

often the degree of responsibility shared by the resident is dependent upon the personality factors of the patient and of each private physician associated with the hospital. Many, of course, are conscious of their obligation to cooperate with the resident's training: they cooperate to any extent consistent with their own responsibility to their patients.

The desire on the part of private physicians to offer residents an "opportunity," however, is not a universal one among all physicians in practice. Many feel, and with strong justification, that their own patients should be totally cared for by themselves.

Obviously, a great divergence of opinion exists on this important and pressing problem. Certainly some give and take appears necessary if private patients are to fill the gap in ward service beds. The resident has already met some give, some take, and many different "attitudes" among private physicians concerning their patients. It might be interesting to detail a few outstanding examples.

Decent

CALL ME WHEN YOU'RE THROUGH The first attitude is that of the "real decent" (from the resident's point of view) prac-

ticing physician or attending. He introduces the resident to his private patient: "Mrs. Williams, may I present Dr. Jones. Dr. Jones is on the hospital staff and is specializing in gynecology. We work together quite closely here at the hospital. I would like you to consider him your own doctor, just as you do me. He will be in constant touch with me on your progress and I, of course, will be in to see you every day."

Often, this type of attending will then discuss—solely in the interests of rapport and for the psychological value to the patient—some incidental fact about Mrs. Williams' condition. The resident will nod knowingly. Mrs. Williams will smile and feel well taken care of. Later, to the resident alone, the attending might say. "Work this up. Check with me on any heavy cost item first. Otherwise go ahead as if she were your own patient. *Call me when you're through.*"

This type of practicing physician has bridged the often delicate, patient-doctor relationship to permit the resident responsibility.

LOOK BUT DON'T TOUCH! At the other extreme is the "blood and scut" attending who seems to expect all infusions, bloods and charts to be done immediately or

about fifteen minutes before he orders them. But he will blow his top if the patient gets so much as an aspirin without his say so. His written order may be a brief: "no pelvic or rectal by house staff."

Attitude

LET'S TALK THIS OVER Between these extremes can be found the majority of practicing physicians. The resident learns to play them by ear, to sense how much freedom and authority he might be given in each case.

Before writing orders, this type of physician will usually sit down and discuss each step of the work-up or therapy with the resident. Usually he will consider (and often accept) suggestions offered by the resident. Even when the resident's idea seems a bit far-fetched to this physician, if the cost is not excessive and the care of the patient not endangered, the attending, *aware of his personal role* in the education of the resident, will occasionally permit the resident to go ahead.

And it is with this type of attending that the resident himself *must be certain that his own attitude is good.*

The smart guy, the surly, the generally non-cooperative resident will hardly get an approv-

ing nod from the attending, much less any patients. As one attending put it, "the resident who is obviously doing the hospital no favors but is in this thing to get all he can get, regardless of how he gets it, will, in the long run, get damn little."

Thus, the private patient as a teaching patient often comes naturally; but only after kindred attitudes and a team idea of co-operation for the welfare of the patient has been established among the staff.

One thing is obvious: patients, however they may be classed, must be available in all residency programs.

Approval

Unless the attending staff of a hospital in which ward patients are scarce shares responsibility with and delegates sufficient authority to the resident staff relative to the care and treatment of their semi-private or private patients, the quality of its program will deteriorate. The specialty boards involved may withdraw their approval of the training program. When this occurs, it follows that the quality (and quantity) of the resident and intern staff will fall off rather sharply.

And who would suffer most in this situation? Unfortunately, but

inevitably, the patient.

The provision and continuance of top-flight medical care and treatment within our hospitals by practicing physicians and sur-

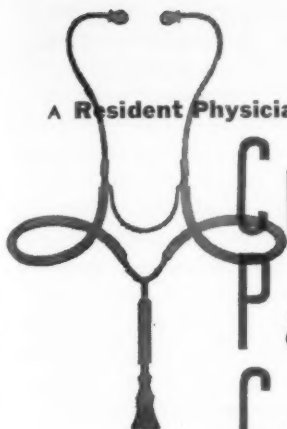
geons can always be accomplished more easily when they are assisted by hardworking, intelligent and interested residents and interns.



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A Resident Physician MONTHLY FEATURE

Clinical Pathological Conference

University of Michigan Medical Center

This 16-month-old white female infant had been well until the age of 6 weeks when she developed frequent respiratory infections and a chronic cough. At 3 months of age she began to have three to four loose, watery, foul smelling stools daily, which were greasy after ingestion of fatty foods. The cough became much worse at 5 months of age and was productive of a thick, yellow sputum. Breathing became labored. The child always had had a good appetite and had eaten ravenously when given

food. She had been seen at the University Hospital four times.

Temperature was 100.6°; blood pressure, 90/65 mm Hg; pulse, 140/minute; respirations, 35/minute and labored. The baby was malnourished, irritable, and mildly cyanotic. There was clubbing of the fingers. The neck veins were moderately distended. There were shotty axillary and inguinal lymph nodes. A moderate increase in the anteroposterior diameter of the chest was noted. The diaphragm was low and showed poor excursion. The

The clinical pathological conference at the University of Michigan Medical School and Hospital is unusual in that most of the cases are presented by senior medical students and discussed by a clinician, pathologist and radiologist. Two cases are presented weekly for a 45-week period in each school year. So-called unknown cases are presented weekly at an additional pathological conference sponsored by the departments of internal medicine, pathology and radiology for the house staff and students. The following is a student presentation. Participants include four students, a professor of pediatrics, an instructor in radiology, and a professor of pathology.

baby was dyspneic, with most of the difficulty occurring during inspiration. There was retraction of intercostal spaces with inspiration. The lungs were hyperresonant with harsh, crackling, inspiratory rales throughout both lung fields. The aortic second sound was louder than the pulmonary second sound. The abdomen was protuberant and tympanitic. The skin over the abdomen showed a mild heat rash. The liver was palpable 6 cm below the right costal margin.

Chest films demonstrated diffuse linear and nodular infiltra-

tions throughout both lung fields. There was marked emphysema. Striking enlargement of all cardiac chambers was noted.

Urinalysis revealed one-plus albumin and one-plus sugar. Hemoglobin was 11.8 gm %. White blood cell count was 14,800/cu mm with 49% polymorphonuclear leukocytes. The white blood cell count rose to 31,000/cu mm two days after admission. Three stool examinations indicated a lack of trypsin activity. The chloride content of perspiration was 124 mg %. Electrocardiogram revealed right axis deviation. Culture of the nasopharynx revealed *Pseudomonas aeruginosa* as the predominant organism. Mantoux test O.T., 1:4000, was negative after 48 hours.

Hospital course

On admission the patient was placed in a croupette with oxygen. Albamycin and digitalis were given. She improved slightly on this regimen for the next few days. However, her heart rate remained rapid and the liver remained palpable 5 cm below the right costal margin. After finding *Pseudomonas aeruginosa* in the nasopharynx, polymyxin B was started intramuscularly. The patient gradually became more

cyanotic and lethargic. On the ninth hospital day she began to vomit. Respirations ceased at 11:40 A.M.

Summary

In summary, we have a 16-month-old baby girl who at the age of 6 weeks first began to have evidence of respiratory infection. At 2 months of age she showed signs of gastrointestinal disturbances, with frequent bulky foul-smelling stools. Fourteen months later she succumbed with severe cardiorespiratory insufficiency. The final clinical diagnosis was *fibrocystic disease of the pancreas*, with severe bronchitis, pneumonia, emphysema, and cor pulmonale.

DR. WATSON: I would like to ask one question of the previous discussant. Was there a family history of fibrocystic disease or anything otherwise significant in the patient's family history?

ANSWER: This was the only child. No family history of this or other similar diseases was elicited.

Roentgenograms

We have two examinations of the chest of this child, the first in June of this year. In a frontal examination, the chest appears to be somewhat over-distended.

The ribs are elevated and the intercostal spaces are prominent. There is parenchymal abnormality in both upper lung fields. This appears as an ill-defined patchy granular infiltration. The lower lung fields appear to have an increase in radiolucency.

The heart, on frontal projection, is normal in contour and size. There is a slight increase in prominence of the mediastinal shadow on the right; however, this is within the limits of normal. There is a contour in the right hilar region that may represent a slightly enlarged lymph node. The lateral film at that time shows that the diaphragm is somewhat depressed and flattened. The heart appears somewhat increased in size in its anterior-posterior diameter and the parenchymal abnormality in the lung is again apparent. It was felt that this represented pneumonia type, with generalized emphysema.

These changes were thought to be compatible with fibrocystic disease, particularly since an examination in September showed persistence of the parenchymal abnormality in both upper lung fields. The abnormality increased in degree in the lower lobes. At this time, September, there is a

striking enlargement of the cardiac silhouette. It appears to be a generalized enlargement of the heart. No specific chamber enlargement is identified.

Again, the diaphragm is depressed. On lateral view we see the abnormal markings. There is some increase in anterior-posterior diameter of the chest.

The findings are typical of chronic pulmonary infection with emphysema, the enlarged heart suggesting failure. All of these changes are suggestive of those in advanced fibrocystic disease of the pancreas.

Gross necropsy

The body of this 16-month-old female infant was malnourished. It measured 78 cm in length and weighed 17¼ lbs. The anterior-posterior diameter of the thorax was increased. Clubbing of the fingers and toes was noted. The subcutaneous panniculus was markedly reduced in amount, with that over the abdominal area being 3 mm in thickness and over the thoracic area 1 mm thick. The omentum was almost devoid of fat. The edge of the liver was 4½ cm below the xiphoid process and 2½ cm below the right costal margin.

The leaves of the diaphragm were at the levels of the left 7th

and right 6th intercostal spaces. The cardiac apex was 6 cm to the left of the midsternal line, in the 7th intercostal space.

The lungs were voluminous. Both pleural cavities were filled by the distended lung tissue. The lungs did not collapse when the chest was opened, and overlapped 1 cm at the 2nd interspace anteriorly when the sternum was removed. The left lung measured 15 x 11 x 5 cm and weighed 100 gm; the right lung, 14 x 11 x 4 cm and weighed 150 gm. The lungs were pale in color and spongy in consistency. The posterior portion of the right lower lobe was firm in consistency and mottled red in appearance.

Upon sectioning the lungs, no edematous fluid was expressed, but an abundance of green, thick, tenacious material was noted. This material was present in bronchioles as well as in the larger air passages. The hilar lymph nodes were slightly enlarged.

The heart was enlarged; it measured 8 x 6½ x 4½ cm and weighed 100 gm. The right ventricle was enlarged and constituted almost the entire anterior surface of the heart when first viewed in the body. Upon opening the heart the right ventricle was enlarged, the musculature

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was hypertrophic, and the right ventricular wall was 8 mm in thickness, while the wall of the left ventricle was only 5 mm thick. The large intestine, particularly the transverse, descending and sigmoid portions of the colon, had a thickened wall which on section appeared to be the result of hypertrophy of the muscle.

The pancreas was firm in consistency, but the size was not materially reduced. The cut surface showed an increase in lobular demarcation but was not strikingly changed grossly. The pancreas measured $8 \times 2\frac{1}{2} \times 1\frac{1}{2}$ cm and weighed 32 gm. The gallbladder was small and thick-walled. Thick, tenacious, sticky, almost colorless material was present in the lumen. Salivary glands were not dissected. The gross pathologic diagnosis was essentially the same as the final clinico-pathologic diagnosis given later.

Microscopic findings

The first section is from the trachea and esophagus. In the trachea we see an increase in prominence of the mucous glands. On the mucosal surface some of the glands exude thick tenacious mucin into the lumen of the trachea. There is some thickening of the basement membrane of the mucosa. Inflammatory cellu-

lar infiltration is present in and around the mucous glands. Active chronic mucopurulent tracheitis.

The second section is that of lung and the dilatation of bronchioles is the striking feature. In the low-power projection areas of emphysema are noted. Around the bronchioles there is cellular infiltration and some congestion.

Under a higher power, the bronchioles are filled with thick mucin and a cellular exudate. Surrounding the bronchioles in cellular infiltration, indicating chronic pneumonitis inasmuch as most of the cells are lymphocytes. Congestion and emphysema are again demonstrated. The third section is a frozen section of liver stained with fat dye. Around the central veins there is evidence in this preparation of degenerative fatty infiltration. This change is practically limited to the area of the central lobular portion of the liver. While this change is not a specific finding in this disease, it is probably the result of anoxemia associated with right ventricular cardiac failure and massive congestion of the central lobular areas of the liver.

While minimal in this case, focal fibrosis of portal trinites of the liver is seen in fibrocystic disease of the pancreas. Focal bili-

ary fibrosis is associated with dilatation of small bile ducts and cellular infiltration in the trinities. In the section of gallbladder Aschoff-Rokitansky sinuses are striking, particularly in such a young individual. The sinuses contain thick tenacious mucin, supporting the contention of the abnormality of mucin in fibrocystic disease or mucoviscidosis.

Such changes are, in this case as in most examples of this condition, not limited to the epithelium of the pancreas. The section of small intestine shows swollen goblet cells which contain and are distended by mucin. The section of the skin shows prominent sweat glands. The section of pancreas contains abundant fibrous connective tissue. There is dilatation of ductules and acini and abundant thick tenacious mucin. The plugging of ductules by the thick mucin results in dilatation of the ductules and acini. Atrophy of acinar tissue results, as well as fibrosis.

Correlation

Fibrocystic disease of the pancreas is a hereditary condition which uniformly has had a bad prognosis. It was first described in 1924 by Hadfield and Clarke in England, but did not reach

clinical significance until 1938 when Dorothy Andersen gave the classical description of 49 cases.

A recent survey by di Sant'Agnese indicated an incidence of 2 cases of fibrocystic disease per 1,000 live births. Of 379 cases, only two were Negroes. There has not been a substantiated case reported in a Mongolian. The disease is known to be familial and is thought to be inherited as a Mendelian recessive.

In other words, only the homozygous recessive can exhibit the disease, but heterozygous carriers may show subclinical manifestations, as has been demonstrated by laboratory studies. Similarly, there have been cases with generalized involvement of mucous glands noted at autopsy where there had been no preceding symptoms. It is estimated that 2 to 18 percent of the general population who carry the recessive gene of this disease do not show symptoms.

Glands

The basic defect is a generalized abnormality of the physiochemistry of most, if not all, of the exocrine glands of the body. Although the glands themselves are not originally morphologically involved, their secretions are altered, giving rise to secondary

changes which produce the symptoms of the disease. Mucin-producing glands are the most strikingly involved. It is thought that the carbohydrate portion of the mucoprotein is altered, giving rise to an unusually sticky, tenacious material of low water solubility, which clings to the walls of the involved glands and ducts.

So while the basic defect is the production of abnormal secretion, it is the intraluminal obstruction caused by these altered secretions which causes most of the clinical symptoms. The onset of clinical symptoms and the prognosis are determined by the location and extent of the obstructive processes.

The major areas of involvement are the pancreas, liver, gastrointestinal tract, lungs, and sweat glands. The severity of involvement of any one area varies from patient to patient. Why some children show primarily a pancreatic defect and why others show primarily pulmonary involvement is unknown. It is now assumed that the variety of response occurs as a varied expression of the unknown basic defect, and the involvement of the different areas occurs independently.

In contrast to celiac disease, fibrocystic disease is usually manifested in the first few months

of life. In a study reported by Charles May, 63 percent of the patients showed symptoms at or shortly after birth, and 86 percent showed symptoms before the age of 3 months. Chronic fibrocystic disease accounted for virtually all pancreatic insufficiency in children, according to the di Sant'Agnese study reported earlier. Involvement of the pancreatic ducts with obstruction gives rise to the symptoms which are classical in this disease. However, it is now known that 10 percent of the patients show no evidence of pancreatic involvement.

Secretion retention

Obstruction of the pancreatic ducts results in retention of pancreatic secretions and cystic dilatations of the ducts and acini with atrophy and fibrosis of the exocrine portion of the gland, but without involvement of the islets of Langerhans. The symptoms arise because pancreatic lipase, amylase, and trypsin are prevented from entering the duodenum, with a resultant decrease in digestion and absorption of proteins, fat, and complex carbohydrates. As a result, fats, proteins, carbohydrates, and fat-soluble vitamins may not be utilized; as much as 50 percent

of the protein may pass undigested through the gastrointestinal tract and be lost in stools, which become mushy, bulky, greasy, and foul-smelling.

It is necessary to emphasize the word bulky because with proper regulation of diet and low fat intake the stools may not be frothy or mushy. In other words, the examination of one stool may appear normal, although the total daily output may be massive. As a result of the decreased absorption of fats, proteins, and carbohydrates, the symptoms of pancreatic involvement are profound malnutrition, avitaminosis, and retardation of growth and development.

Vitamin A deficiency gives rise to xerophthalmia and hyperkeratosis. Vitamin D deficiency results in rickets. Originally it was thought that rickets was very common in this condition; however, the di Sant' Agnese study showed that rickets rarely occurs in this disease. Vitamin K deficiency may result with a decrease in prothrombin levels and a bleeding tendency.

The children develop ravenous appetites as a compensatory mechanism. This may be the chief complaint when the parents consult a physician with such children. If the diet is restricted

or an intercurrent infection causes a decrease in appetite, profound malnutrition may result. Thus, the most important symptoms of pancreatic involvement are: abnormal stools, malnutrition, retardation of growth and development, and excess appetite.

Obstruction

It recently has been shown that necropsies on many of these patients show areas of biliary obstruction with focal biliary fibrosis, due to obstruction of the radicles of the biliary tree by inspissated mucin. In most instances the change is not severe enough to produce symptoms. However, in about 2 percent of the cases there is progression of the obstruction to fibrosis and development of multilobular biliary cirrhosis.

With resultant portal hypertension there are hepatosplenomegaly, hypersplenism, bleeding tendencies due to inadequate platelets and esophageal varices, ascites, and abnormal liver function tests. Icterus is usually absent or minimal. Multilobular biliary cirrhosis is said to account for one third of the examples of portal hypertension seen in childhood.

Ten to 15 percent of children with fibrocystic disease of the

pancreas present with meconium ileus and obstruction of the small intestine at or shortly after birth. There are two possible explanations for the phenomenon: (1) with decreased pancreatic trypsin the normal meconium is not liquified (2) the abnormally sticky intestinal secretions may result in increased tenacity of the meconium and intestinal obstruction. Occasionally this may result in volvulus of the small intestine or the bowel may perforate and meconium peritonitis result. The condition may be fatal without surgical intervention. Fifty percent of the patients with meconium ileus are salvaged by surgical intervention. It is noteworthy that meconium ileus is not necessarily the sign of unusually severe disease.

Pneumonitis

Following successful surgical intervention the child may follow the normal course of the disease, developing pancreatic, pulmonary, and sweat gland involvement. At some time during the course of the disease virtually all patients show some degree of pulmonary involvement, with the onset usually occurring in infancy or early childhood.

Ninety percent of the patients with fibrocystic disease die with

chronic pneumonitis. The intra-bronchial secretions are thick and tenacious. The child develops a dry, hacking, nonproductive cough, usually within the first 3 months of life. Intercurrent infection may cause an increase in secretions which, due to their tenacity, cannot be removed adequately. This results in bronchial and bronchiolar obstruction with multiple areas of localized infection.

Eventually, generalized bilateral obstructive emphysema, and chronic peribronchiolar pneumonia result, leading to respiratory distress, anoxia, CO₂ retention, and air hunger. Terminally, there may be septicemia, fatal lung abscesses, cor pulmonale with heart failure, massive lobar atelectasis, sudden asphyxia, or chronic pulmonary insufficiency. Hence the death is anoxic in type. The predominating organism in the lungs is *Staphylococcus aureus*. With the advent of antibiotics, candida, pseudomonas, and proteus are often found.

In all of the organs mentioned—the pancreas, gastrointestinal tract, and lungs—the disease process is the result of intraluminal obstruction of mucous glands and ducts. Fibrocystic disease manifests itself in a different way in the sweat and salivary glands.

Electrolytes

The secretions of sweat and salivary glands are not abnormally sticky and do not obstruct the ducts, but do contain a high concentration of electrolytes. The sweat of normal children contains 4 to 60 meq. of chloride, and that of children with fibrocystic disease has as much as 160 meq. Similarly, sodium is increased from a normal level of 10 to 80 meq. to 80 to 190 meq.

Less than 1 percent of the patients with fibrocystic disease have normal levels of sweat electrolytes. Thus, determination of sweat electrolytes has become a more important determination than has the determination of duodenal trypsin content in the diagnosis of fibrocystic disease of the pancreas. Twenty percent of asymptomatic relatives of the children with fibrocystic disease have increased sweat electrolytes. The patients with fibrocystic disease who have sweat gland involvement lose sodium chloride and in hot weather have heat exhaustion, vomit, are dehydrated, and show hyperpyrexia. Cardiovascular collapse, coma, and death may result. Both sweat and salivary gland secretions are increased.

The case presented is a classical example of fibrocystic disease.

The pancreatic, pulmonary, and sweat gland involvement was typical. She developed steatorrhea, obstructive emphysema, and died with severe pulmonary inflammation complicated by pseudomonas and staphylococcus infection. She developed clubbing of the digits, cor pulmonale, malnutrition, absence of trypsin in the stools, and sweat chloride concentration of 124 meq.

Recessive

Since fibrocystic disease is inherited as a Mendelian recessive, one-fourth of the siblings of children with the disease may have the disease. In other words, the chance of having a sibling with the disease is 1 in 4. It is very important to differentiate fibrocystic disease from celiac disease, as the prognosis in the two conditions is so different. In either disease the patient may show steatorrhea, malnutrition, and retardation of growth and development. However, 86 percent of children with fibrocystic disease develop symptoms prior to 3 months of age and celiac disease in a child under 6 months of age has not been reported. Similarly, the children with fibrocystic disease have ravenous appetites; those with celiac disease usually have decreased appetites.

Therapy

The therapeutic approaches follow: (1) treatment of the pulmonary infection with antibiotics, croupettes, and postural drainage (2) surgical intervention for meconium ileus and portal hypertension (3) cardiac medications for cor pulmonale (4) salt and electrolyte therapy for salt depletion and heat exhaustion (5) diet regulation for malnutrition.

There is some debate about the amount of fat that should be given to these children. At the University of Michigan Hospital, I believe, the program is a low fat, high carbohydrate, high protein, and high caloric diet. Artificial trypsin is added to increase the digestion of protein, and carbohydrates are given as simple sugars. It is important to give fat-soluble vitamins in water-miscible solutions.

It is noteworthy that the lay press has commented upon the importance of fibrocystic disease, as indicated in a recent release: "Only in fairly recent years have such deadly enemies as polio and leukemia been given general public recognition. And now a crusade is under way against another stealthy slaughterer, which in the last few months has come under the spotlight of public scrutiny. The disease is cystic fibrosis."

Low-fat diet

PEDIATRICIAN: This small, underweight child had a voracious appetite and did, indeed, eat lots of food, but most of it passed through the intestines undigested. Instead of losing the usual 10 percent of the calories which went through the digestive tract, she probably lost 50-60 percent or more.

The matter of the low-fat diet also should be commented upon. Since bile production is impaired and if the liver is involved, a high-fat diet would result in unsplit fat going through the gastrointestinal tract. I think that the use of a normal or a low-fat diet is indicated, one which does not cause the child to be on an unacceptable diet which she may not eat. You don't need to worry about their appetites.

I was at the Cincinnati meeting when Dorothy Andersen described fibrocystic disease and differentiated it from the other types of chronic intestinal indigestion, particularly celiac disease. She told us that fibrocystic disease, previously called congenital steatorrhea, was a separate condition. It was then thought by Wolbach and Blackfan that the chief dysfunction was congenital steatorrhea and that poor absorption of vitamin A re-

sulted in metaplasia of the mucous membranes of the bronchi which were then occluded with mucin and became infected.

Their explanation did not happen to have exactly the right basis, although the sequence of events is the same. Indigestion is only a part and ordinarily not a very important part of this disease. I remember some years ago in one of his papers, Doctor May said, in essence: "As the lungs go, so goes the patient." In other words, if the patient has little pulmonary involvement, he will do all right. That has been our experience here. We have had patients with cystic disease of the pancreas who have had several years of very good health, and that has been during the time in which their pulmonary disease was in remission or in almost complete abeyance.

Variations

When the pulmonary phase of the disease became more prominent, the patient again began to lose weight and to go downhill. It has been thought, of course, that fibrocystic disease is a uniformly fatal disease. Now we begin to realize that there are many variations in the manifestations of this disease and also that there are probably persons who have

part of the picture but may not have the deadly part of the disease. So we will have to revise our thinking, it now seems, by virtue of tests of sodium and chloride in the sweat when applied to other members of the family of a patient with this disease. We are recognizing patients in the third decade who have this disease in a much milder form than did this little girl.

The matter of inheritance must be discussed. This was an only child and the parents are young. This family had undoubtedly asked us about this problem. I hope that they had, and that we advised them. As you have been told, the disease is inherited as a recessive and is likely to affect one child in four born to a couple. But, of course, that ratio would hold only if they had many children, so when you advise people you must tell them that statistically there also is the possibility that the disease might involve the first three of twelve children.

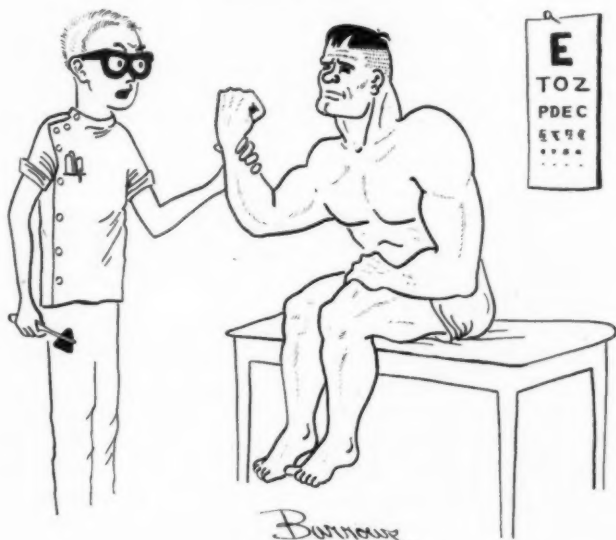
Do not let them conclude that because they have had one child with fibrocystic disease that the next three children will be normal. It has happened once in this hospital to people who were seen in the department of Pediatrics and in the Heredity Clinic, and

when the mother came back with the second child affected with the disease she cried out in anguish: "You told me only one in four!" So we obviously did not make the point clear. We have one family who had four of five children with cystic fibrosis of the pancreas.

Pathological diagnosis

Fibrocystic disease of the pancreas (mucoviscidosis). Acute mucopurulent exacerbation of chronic bronchiolitis and bronchitis with bronchiolectasis and

bronchiectasis. Bilateral pulmonary emphysema and patchy atelectasis. Pulmonary osteoarthropathy. Cor pulmonale. Chronic cholecystitis. Acute purulent exacerbation of chronic fibrosing pancreatitis. Centrolobular lipidosis of the liver. Early rickets (?). Acute cerebral congestion and edema. Lymphoid exhaustion in the thymus, spleen, and lymph nodes. Abundant adrenocortical lipids. Emaciation. Persistence of fetal fat. Slight serous atrophy of adipose tissue.



"Okay, now resist me."

Is the effectiveness of a drug determined solely by what the manufacturer puts into it? The author points to other "ingredients" for you to consider.

The pill is a potent thing. The pen is mightier than the sword, but the pill surpasses both. Like the sword, it can kill; like the pen, it can persuade. Unlike either, the pill can also cure.

One-tenth of one-thousandth of one gram of digitoxin can spell the difference between life and death, and seventy-five millionths of a gram of lysergic acid can produce profound mental aberration in a previously healthy man. These are potent medicines.

But the power of pills does not stop with their pharmacological effects. Medicine—in fact anything a patient gets from a doctor—has symbolic as well as objective meaning. Salubrious or noxious, it can complement or oppose the chemical action of the drug. This symbolic action sometimes exceeds the chemical action of the medicine. Unfortunately the symbolic action is not always easy to recognize and to predict. What's even worse, it is not nullified by disregard. It's still there,

even if you look the other way.

But let's get down to cases. A man spent a month in a rehabilitation center for alcoholics, and when he left he was given a sedative to tide him over the rough spots. At his follow-up visits he seemed to be doing very well, so well in fact that his doctor decided to discontinue the medicine. To this the patient loudly objected. The doctor then learned that his patient hadn't taken the medicine after the first few weeks. Then why insist on renewal of the prescription?

The patient explained that whenever he felt he needed a drink, he took out the tablets and looked at them. The medicine reminded him of the clinic, the clinic of the hospital, and this of

What's in a

what he had learned about controlling his need to drink. As with many people, this seemed to be a case of out of sight, out of mind. Beyond its chemical effect, the medicine had served the patient as an instantly available, tangible reminder of what he knew about managing his

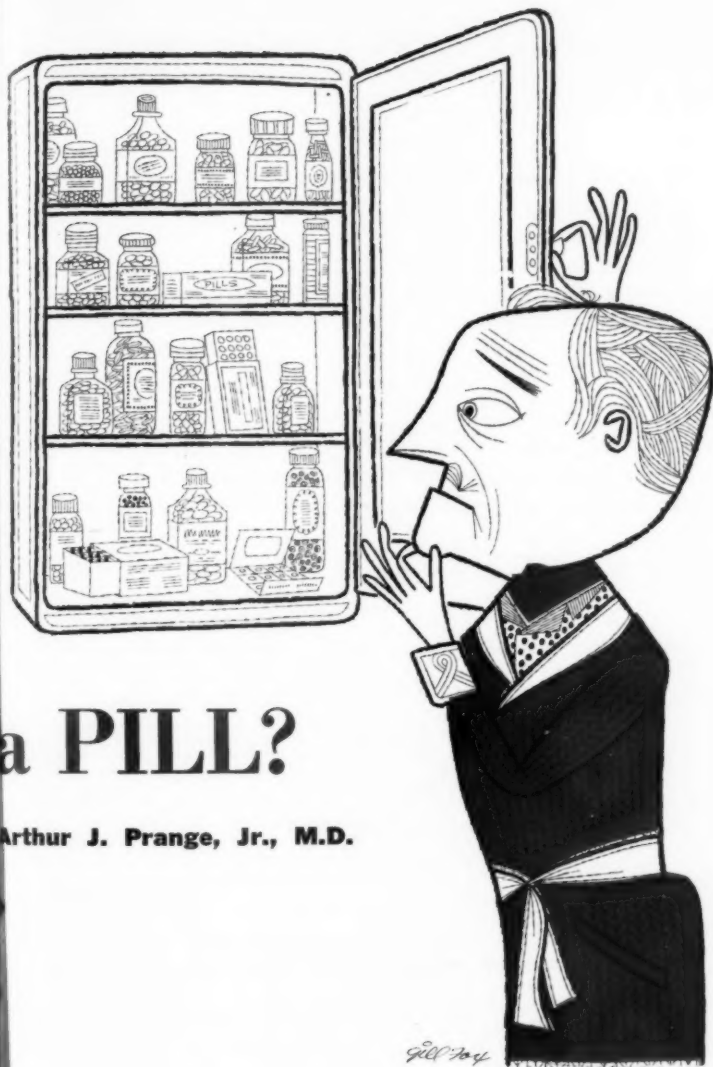
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Arthur J. Prange, Jr., M.D.



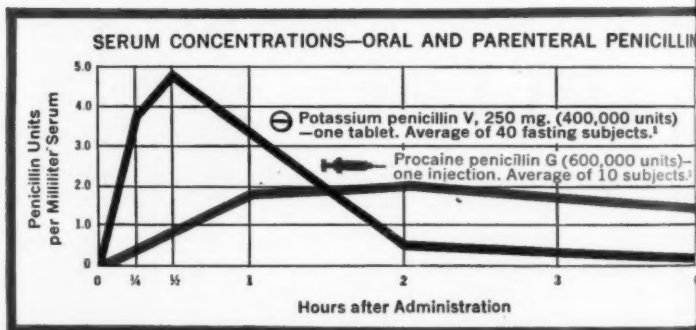
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in oral penicillin therapy

the speed of action you want
the reliability you need

In recent studies involving 107 subjects, effective penicillin blood levels were *consistently* produced within 15 minutes after administration of oral potassium penicillin V. Peak levels were obtained within a half-hour. Even after two hours, effective penicillin blood levels still persisted in *every* subject. At four hours, demonstrable blood levels existed in 93 per cent of subjects.¹⁻²

PEN·VEE K may be prescribed for
all infections responsive to oral penicillin
... and even many usually treated with parenteral penicillin



1. Peck, F.B., Jr., and Griffith, R.S.: Antibiotics Annual 1957-1958, Medical Encyclopedia, Inc., p. 1004. 2. Wright, W.W., and Welch, H.: Antibiotic Med. 5:139 (Feb.) 1958. 3. White, A.C., et al.: Antibiotics Annual 1955-1956, Medical Encyclopedia, Inc., p. 490.

The antibiotic that is prescribed most often for common bacterial infections . . .

penicillin

In a form that produces high penicillin blood levels rapidly and reliably . . .

potassium penicillin V

In two dosage strengths and preparations to assure acceptance by patients . . .

PEN·VEE® K

Liquid: Penicillin V Potassium for Oral Solution; Tablets: Penicillin V Potassium, Wyeth

*flexibility of dosage form and high potency
assure acceptability of full therapeutic
dosage*



LIQUID

SUPPLIED: *Liquid:* raspberry-flavored, 125 mg. (200,000 units) per 5-cc. teaspoonful; peach-flavored, 250 mg. (400,000 units) per 5-cc. teaspoonful. Supplied as vials of powder to make 40 cc. *Tablets:* 125 mg. (200,000 units) and 250 mg. (400,000 units) in vials of 36.



TABLETS



Philadelphia 1, Pa.

problem. The patient insisted he needed the medicine. Who would say he didn't?

Interest

Of course there might have been much more to it than this. The medicine might have stood for a continuing concern and interest on the part of the doctor. It might have partly satisfied a craving to be looked after. The medicine might have been used to prove to his wife that he was getting something—something to show—for his clinic visits. In another alcoholic, the medicine might have been evidence that he “didn’t have” a mental problem, and this might—emphasize *might*—have been the best way to handle this particular patient.

The point is this: human beings can use almost anything to symbolize almost anything else. It is not always easy to know what a given patient is making of his medicine, but is sometimes very important.

About The Author

Dr. Prange was graduated from a Michigan medical school, took a rotating internship and one year of residency before being recalled for Navy service in 1952. Following service, he completed three years of residency in psychiatry. The author is presently an instructor in psychiatry at the University of North Carolina Medical School. This is Dr. Prange's second contribution to your journal.

Every doctor every day finds that some of his prescriptions are working better than he had dared hope, while others, given with equally good indications, are a dismal flop. Considerable head scratching goes into efforts to account for such puzzles. Probably a better way is to talk to the patients about it. Even watching them can help.

Prescription

A woman in her forties keeps coming back for headaches for which no very convincing cause can be found. Nothing works very well for long. Everything works a little, temporarily. You write a prescription and slide it across your desk. She looks at it a moment and slowly picks it up with a sigh. It seems a very long silence before she stands up and says, thank you.

What's going on in this scene? As a disinterested party some things are very obvious to us. First of all, this patient earnestly

wants something done about her symptoms: she keeps coming back. Secondly, the doctor wants to help. That's his job, and besides, he continues to see her. Third: there is some kind of interchange, some communication between them. She describes the sorts of things that she has learned that doctors want to hear—or seem to: where does it start, what time of day, where does it go, etc.?

So far so good, for all this is fundamental and necessary. But then the doctor does something, which amounts to a reply to the patient in the language that she has begun with. He gives her a prescription. Again, this may be the best thing to do. But whatever the merits of the particular case, I think we can legitimately question the doctor's timing. His prescription, fully indicated, let us assume, has written "finis" to the conversation. Prematurely given, it has closed the door to further exploration of the problem. The patient knows this all too clearly; she sighs and leaves the consulting room with evident reluctance — evident if one can see it.

Everyone sees patients indignant because the doctor down the street said (allegedly), "It's all in your mind, your imagination,

your nerves," etc. One also hears, and with increasing frequency, "Every time I went to him he gave me some new pill. That's all he ever did."

The point is that some patients do want to talk about more than their symptoms. Some can profit from such an experience, and some are prevented by well meaning physicians who feel they must quickly "do something!"

Results

So pills sometimes work benefit far beyond their pharmacological potentialities, and they sometimes block the development of a fully useful relationship between the doctor and his patient.

If all this is true, then how can one discover what a given medicine does, pharmacologically, in a clinical setting?

The situation is not clarified by giving a certain drug to a certain number of patients with a certain illness and then saying that a certain percentage were benefited.

The physician of an older generation knew this when he was confronted by the enthusiasm of a younger colleague for a new remedy. "Use it," advised the older doctor. "Use it while it works."

One refinement is to give a

placebo to an equal number of patients with similar complaints and to compare the results. But naturally, it is difficult for physicians to give "nothing" to sick people. Their lack of enthusiasm rubs off on their patients, and the placebo is put at an unfair disadvantage.

Well, then use the double-blind technique. Let neither the patient nor the doctor know what medicine is being used. In such a situation, one usually finds that the placebo does have some clinical effect. Moreover, it can have toxic side reactions. A certain number of people develop nausea, dry mouth, etc. from a placebo just as they do from any active drug.

The double-blind technique may not wholly eliminate the effect of the doctor's personality. A recent study showed this very clearly. Doctor A and Doctor B, themselves "blinded," in random order gave a placebo and a test drug to patients with similar complaints. About three-fourths of the patients of each doctor reported improvement. On the surface this sounds like an expected result, but when the patients were identified according to what they had received, things were a bit confusing. Dr. A's improvements occurred about two-

thirds with the drug, one-third with the placebo. Dr. B's improvements occurred almost wholly with the drug.

The discrepancy led the researchers to observe what happened between the doctors and their patients when the pills were dispensed. This is what they found. Dr. A took a phlegmatic view of the matter. To his patients he said in effect, "Here is a new drug. We think it might help." Dr. B, on the other hand, was sanguine. He told his patients, "Here is a new drug. We've had good results with it. It will probably help you, too."

Apparently A's patients had about as much confidence in him as B's did in B, for approximately equal numbers improved. But B's patients were prepared to experience a potent drug effect. When those of them who did receive the drug *did* perceive an effect, their own expectations, stimulated by B's, took hold and exaggerated the improvement. Why didn't B's placebo patients do as well as A's? This is somewhat obscure. It may be that their heightened expectations turned to disappointment when they failed to perceive a pharmacological effect. A further refinement might be to include with the test drug and the placebo a

standard drug similar to the test drug. This would have given B's enthusiasm an opportunity to itself in an additional direction.

In any case, the point should be clear that *it is difficult, even with meticulous care, to eliminate from drug results the effect of the doctor-patient context in which that drug is given.* In uncontrolled clinical settings the effect of this context is certainly immense.

There is nothing wrong with

this; one needs only to understand it. A drug can come between the doctor and his patient or it can advance them toward their common goal. And these effects need not happen hit or miss. With a little observation and thought on the doctor's part, a useful drug can become all the more useful.

The question of what's in a pill is not a simple one. It all depends. It depends on what the manufacturer, *and the doctor, and the patient,* put in it.

References

1. The Symptomatic Relief of Anxiety with Meprobamate, Phenobarbital and Placebo.

E. H. Uhlenhuth, Arthur Canter, J. O.

Neustadt, and H. E. Payson. In Press.

2. E. H. Uhlenhuth, personal communication.



"Well sir, if you're really interested, it happened when I finished my internship and started looking for a place to practice..."

One of a series on leading resident-intern centers

University of Michigan

In this large Midwest education and research center some 40,000 clinic patients and 17,000 inpatients are treated annually, providing teaching material for 122 residents in 18 specialties and subspecialties.

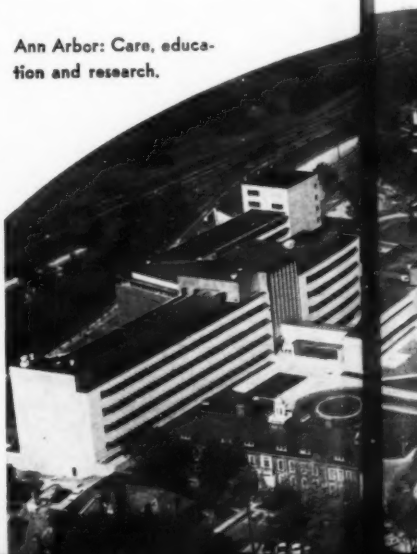
The University of Michigan Medical Center this year observes the 90th anniversary of its University Hospital — the nation's first university owned hospital. It was established in 1869. Located in the city of Ann Arbor, 35 miles from Detroit and 55 miles from the State Capitol, the vast center is a focal point for patient service, medical education and research in a three-state area.

The hub of the Medical Center for clinical services and training programs is the Main Hospital. Eight different buildings, providing total facilities for 1050 inpatients and up to 1000 outpatients daily, radiate from the Hospital proper. All but two of these buildings have been constructed within the past ten years.

They include the Outpatient

Clinic (24 daily clinics), Women's Hospital (76 beds and 83 bassinets), the Neuropsychiatric Institute (85 beds), Veterans Readjustment Center (47 beds), Childrens Psychiatric Hospital (59 beds), Kresge Research In-

Ann Arbor: Care, education and research.



an Medical Center

stitute, Alice C. Lloyd Radiation Therapy Unit, and Simpson Memorial Institute.

The bed complement of the Main Hospital is 725. Construction will soon begin on a 200 bed children's hospital and a mental health research institute, and plans are underway for a cancer research unit and a chronic disease and rehabilitation hospital.

The present facilities cost approximately \$16 million. Within the next five years the total units

will represent \$37 million in construction outlay.

Although the Medical Center receives appropriations from the state for initial construction, the full costs of operation (with the exception of the psychiatric units) are met with funds received from patients for services rendered; no state subsidy is provided. The cost of operation totals approximately \$25,000 per day at the Hospital.

The University of Michigan





SYMPOSIUM REPORT:

ALTAFUR in antibiotic-resistant staphylococcal infections

ALTAFUR proved superior to any other single agent against staphylococcal infections encountered in the pediatric section of a general hospital. Introduced during an epidemic of severe staphylococcal pneumonia and bronchiolitis in younger children, ALTAFUR was employed in treating a total of 59 infants or juvenile patients, most of whom had upper or lower respiratory tract involvement. Almost all had been given antibiotics without effect; 34 were judged severely or critically ill. Cures were obtained in 54 of these patients after a 3 to 10 day course of ALTAFUR. There was only one failure (results were inconclusive in the remaining four cases). Mixed infections with *Pneumococcus* or *Streptococcus* sp. also responded readily.

ALTAFUR was administered orally in varying dosage: the optimal dose is believed to be about 22 mg./Kg. daily.

Side effects were minimal, being limited to gastric intolerance in a few cases, usually controllable by giving drug with or after meals. Laboratory studies revealed no adverse influence on renal, hepatic or hematopoietic function, nor other signs of toxicity.

Lysaught, J. N., and Cleaver, W.: Paper presented at the Symposium on Antibacterial Therapy, Michigan and Wayne County Academies of General Practice, Detroit, Sept. 12, 1959 (published Nov., 1959)

bright new star
in the antibacterial firmament

ALTAFUR[®]

brand of furaltadone

the first nitrofuran effective orally
in systemic bacterial infections

- Antimicrobial range encompasses the majority of common infections seen in everyday office practice and in the hospital
- Decisive bactericidal action against staphylococci, streptococci, pneumococci, coliforms
- Sensitivity of staphylococci in vitro (including antibiotic-resistant strains) has approached 100%
- Development of significant bacterial resistance has not been encountered
- Low order of side effects
- Does not destroy normal intestinal flora nor encourage monilial overgrowth (little or no fecal excretion)

Tablets of 50 mg. (pediatric) and 250 mg. (adult)

Average adult dose: 250 mg. four times a day, with food or milk

Pediatric dosage: 22-25 mg./Kg. (10-11.5 mg./lb. body weight daily in 4 divided doses)

CAUTION: The ingestion of alcohol in any form, medicinal or beverage, should be avoided during Altafur therapy.

NITROFURANS—a unique class of antimicrobials

EATON LABORATORIES, NORWICH, NEW YORK



Basic science buildings and the nursing school are the first in a \$15 million expansion program

serves as a consultative and diagnostic center for patients referred by physicians from 83 counties in the state.

Each patient is referred to the University Hospital, examined in the outpatient department and assigned to a clinical service. All members of the housestaff participate daily in rounds. The wards, units of 50 beds each are particularly suitable for teaching and care of the patient. The main hospital has two such wards on each of the six floors. Between these wings are semi-private rooms used primarily for patients needing more intensive care.

Private

Private room facilities constitute about 10 percent of the total Hospital bed complement and are used in the clinical training programs. They are located on three floors with 32 beds in each unit. These areas were completely

modernized in 1958, and include electrically operated, patient-controlled beds, inter-communication between the bedside and nurses' station and piped oxygen to each room. The total hospital facilities make available to the resident patients on private, ward and intensive care units.

Eleven operating rooms, including one specifically designated for open-heart surgery, are also housed in the Main Hospital. Adjacent to them is the recovery room, staffed 16 hours a day and with facilities available for 12 patients at a time. Approximately 40 operations are performed daily in the Main Hospital, most of them major procedures.

Integral parts of the Medical Center are the largest medical school and school of nursing in the country; immediately adjacent to the Center is one of the nation's eleven schools of Public Health.



expansion program at U. of M. Medical Center.

Campus atmosphere

The University Medical Center is part of the University of Michigan campus, making readily available such activities as "Big Ten" football, concerts, plays, lectures. Recreational facilities in the community include six golf courses, and there are 50 lakes within a radius of twenty miles.

Residency

Appointment in all residency programs is for a period of 12 months with renewal annually. Residents are enrolled in the Department of Postgraduate Medicine of the University of Michigan Medical School. The teaching programs are supervised by the respective departmental chairmen or heads of clinical departments. Approximately 40,000 clinic patients (involving 240,000 clinic visits) and over 17,000 inpatients annually, pro-



Emergency care in new outpatient building which has four operating rooms.

vide the material for teaching and training.

Organization

Broad policies regarding patient services are established by a Board-in-Control of University Hospital. The board is appointed by the regents of the University of Michigan and includes, among



Medical illustrator records details of surgical procedure for use in teaching.

others, the dean of the Medical School, the director of the Hospital, and a senior clinical representative.

The Senior Medical Advisory Staff — composed of professors and associate professors of the Medical School — recommends the professional policies for patient care. In addition, an executive committee of the Medical

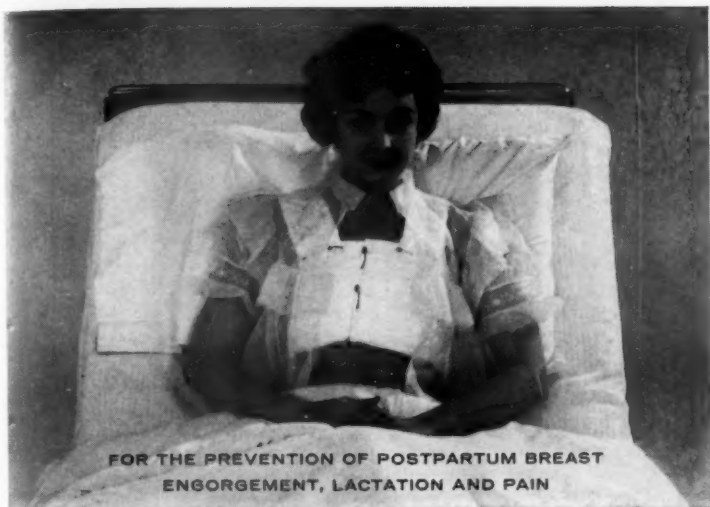
School develops policy relative to teaching and clinical services. Close coordination of teaching and patient service is provided by the presence of the director of the Hospital and the dean of the Medical School on policy-making bodies of both the Hospital and the Medical School.

The Junior Medical Advisory Staff—consisting of assistant professors, instructors, and one resident representative from each service—completes the staff organization.

Part-time practice privileges are granted to only a limited number of staff members. Of the 1050 beds, approximately 90 are designated for private patients, but these patients are available for teaching in the residency programs. Residents follow the schedules established on their specific services, and assist in teaching interns and other residents junior to themselves.

Job opportunities

Wives of residents seeking full or part-time employment can consult the personnel offices of the University and the Hospital. The University of Michigan employs over 2000 secretaries, and the Hospital has 3000 employees, many of them physicians' wives. The Ann Arbor area also



FOR THE PREVENTION OF POSTPARTUM BREAST
ENGORGEMENT, LACTATION AND PAIN

Vallestril®

(brand of methallenestril)

- avoids most withdrawal bleeding
- minimizes secondary breast symptoms and uterine subinvolution
- “... causes fewer gastrointestinal upsets’ than does diethylstilbestrol.”

Schneeberg and his associates² gave Vallestril to 198 patients with postpartum breast engorgement, pain and lactation. They reported: “The patients ... achieved over-all results ... somewhat better than those in patients receiving 3 mg. of diethylstilbestrol. ... Untoward effects, even when large doses were used, were rare. The ‘slight bleeding’ recorded ... was probably of no significance and was doubtless no more than would have occurred in these individuals without therapy.”

Napp, Goldfarb and Massell³ conducted a controlled study in which 207 postpartum patients received Vallestril, 213 patients were given diethylstilbestrol and 193 patients did not receive hormone therapy. “The stilbestrol treated group showed a significantly greater incidence both of interim bleeding and of hypermenorrhea than did the control or the Vallestril treated groups.”

These authors concluded that “Vallestril is a

superior synthetic estrogen for the suppression of lactation. The low incidence of interim bleeding and of hypermenorrhea constitute a most important characteristic of the drug.”

Only two 20-mg. tablets taken daily, for five days, suppress lactation and relieve engorgement and pain. Dosages for indications other than the suppression of lactation are given in Reference Manual No. 7. G. D. Searle & Co., Research in the Service of Medicine.

1. Council on Drugs: New and Nonofficial Drugs 1958. Methallenestril, Philadelphia, J. B. Lippincott Company, 1958, pp. 477-478.

2. Schneeberg, N. G.; Ferczek, L.; Nadine, J. H., and Perloff, W. H.: Methallenestril, a New Synthetic Estrogen, J.A.M.A. 161:1062 (July 14) 1956.

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SEARLE

UNIVERSITY OF MICHIGAN MEDICAL CENTER CONFERENCES

MONDAY

A.M. 8:15 Neuropathology Conference
 9:00 Dermatology-Psychiatric Conference
 11:00 Pediatrics Clinical Conference
 P.M. 12:45 Medical Journal Club
 1:30 Fracture Conference
 3:30 Scintigram Pathology Conference
 4:00 Cardiac Conference
 Surgery-X-ray Conference
 Gastroenterology Conference
 X-ray Staff Meeting

TUESDAY

A.M. 8:00 Dermalpathology Conference
 Gynecology Tumor Conference
 Pediatrics Clinical Conference
 P.M. 12:30 Ophthalmology Journal Club
 Chest Conference
 Medical-Surgical Gastroenterology Conference
 Pediatrics Staff Conference

WEDNESDAY

A.M. 8:00 Allergy Journal Club
 Ophthalmology Grand Rounds
 Polio Respirator Center Staff Conference
 Surgery Grand Rounds
 P.M. 11:00 Pediatrics Clinical Conference
 Anatomy Staff Meeting and Luncheon
 Pathology Journal Club
 Medical Clinicopathological Conference
 Neurology Journal Club
 Obstetrics and Gynecology Clinical Conference

3:00 Surgery Educational Films
 4:00 Pediatrics Surgery Conference
 Thoracic Surgery Conference
 Medical X-ray Conference
 4:15 Otolaryngology Staff Meeting
 7:45 Surgery Staff Meeting

THURSDAY

A.M. 8:00 Clinical Radioisotope Journal Club
 Orthopaedics Open Staff Meeting
 Dermatology Conference
 Obstetrics and Gynecology X-ray Conference
 Pediatrics Roentgenology Conference
 Neurosurgery, Neuroanatomy Conference
 Medicine Staff Conference
 Pathology Slide Conference
 Neurology-Neurosurgery Follow-up

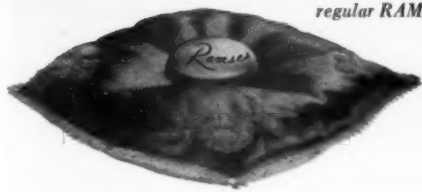
FRIDAY

A.M. 8:00 Gynecology Tumor Conference
 Dermatology-Allergy Conference
 Pediatrics Clinical Conference
 Psychiatry Journal Club
 Clinicopathological Conference
 Tumor Board

SATURDAY

A.M. 8:00 Surgery Staff Conference
 Pediatrics Discharge Conference
 Obstetrics and Gynecology Conference
 Thoracic Surgery Conference
 Neurosurgery, Ophthalmology Conference

regular RAMSES Diaphragm



*cushioned comfort—
now
two ways*

new RAMSES BENDEX
Diaphragm



The cushioned comfort and sensitivity built into both the regular RAMSES® Diaphragm and the new RAMSES BENDEX®, a bow-bend Diaphragm, contribute to the physical ease and emotional security that encourage patient cooperation.

The regular RAMSES Diaphragm, suitable for most women, is distinguished by a soft cushioned rim and flexibility in all planes

to permit complete freedom of motion. The complete unit—the new RAMSES “TUK-A-WAY”® Kit #701 with diaphragm, introducer and jelly, is attractively packaged in a new zippered case which opens top and side.

For those women who need a different type of diaphragm, the RAMSES BENDEX is now available, retaining all the desirable flexibility of RAMSES coil-spring construction. The bow-bend or arc-ing type of construction makes it especially suitable for the woman with structural abnormalities such as cystocele or rectocele. No introducer is required. Further information about the new BENDEX may be obtained from your local Schmid representative.

RAMSES Jelly,* uniquely suited for use with either type of RAMSES Diaphragm, further contributes to the patient's comfort and protection by flowing freely over the rim and surface to lubricate the diaphragm, aid in insertion, and protect the patient for ten full hours.

When you fit your patient with one of these RAMSES Diaphragms you are providing essential inner security. She is assured she can plan her family according to her wishes, safe in the knowledge that she is using not only the most reliable method—diaphragm and jelly, which reduces the likelihood of conception by at least 98 per cent¹—but the most comfortable choice—RAMSES Diaphragm and Jelly.

Ramses®

1. Tietze, C.: Proceedings, Third International Conference Planned Parenthood, 1953.

*Active agent, dodecaethyleneglycol monolaurate 5%, in a base of long-lasting barrier effectiveness.

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UNIVERSITY OF MICHIGAN HOSPITAL RESIDENCIES

RESIDENCY	CHAIRMAN	RESIDENCIES	LENGTH	STIPEND
Allergy	John M. Sheldon	3	1	\$250
Anesthesia	Robert B. Sweet	4	2	160†
Dermatology & Syphilology	Arthur C. Curtis	5	3	160†
Internal Medicine	William D. Robinson	20	3	160†
Neurology	Russell N. DeJong	4	3****	160†
Neurosurgery	Edgar A. Kahn	2	3**	195
Obstetrics & Gynecology	Norman F. Miller	3	4	160†
Ophthalmology	F. Bruce Fralick	6	3	160†
Orthopedic Surgery	Carl E. Badgley	6	3*	195
Otolaryngology	James H. Maxwell	3	4	160†
Pathology	James A. French	5	4	160†
Pediatrics and Communicable Diseases	James L. Wilson	8	2****	160†
Physical Medicine	James W. Rae, Jr.	2	3	160†
Psychiatry	Raymond W. Waggoner	12	4	335
Radiology	Fred J. Hodges	6	3	160†
Surgery	Charles G. Child, III	27	4	160†
Thoracic Surgery	Cameron Haight	3	3***	195
Urology	Reed M. Nesbit	3	3**	195

* In addition to a rotating internship and one year of training in general surgery.

** In addition to a rotating internship and two years of training in general surgery.

*** In addition to a rotating internship and three years of training in general surgery.

**** An additional year of training is available to those qualified and so desiring.

† Denotes first year resident.

has numerous openings each year for teachers in the local schools.

Benefits

The Hospital cafeteria offers a 33 percent discount to the resident staff. House staff members are required to carry Michigan Blue Cross hospitalization or an equivalent health insurance program. All outpatient and professional charges not covered in the insurance are added benefits offered by the hospital for both the staff and their families.

In addition, the resident is entitled to one month vacation each year, which is scheduled by the individual departments.

A separate house staff building connected to the Hospital provides bachelor quarters. Priority

is given to interns and assistant residents, but living quarters are usually available for residents desiring them. Although the Hospital itself does not maintain facilities for married trainees, the University does. University Terrace Apartments, adjacent to the Main Hospital, and the Northwood Apartments, in campus surroundings slightly north of the Hospital, offer modern quarters. In addition, many students and staff members live in homes and apartments in Ann Arbor, at no more than 15 minutes' commuting distance from any section of the community.

Special facilities

An unusual facility at the Medical Center is a complete

Outpatient staff conference in oral surgery, with chairman and resident staff.



color television studio (closed circuit) which is initiating operations at this writing; it will enable medical students and intern and resident groups to view lectures and demonstrations held in many parts of the Medical Center. A special television camera is also permanently installed in one operating room to provide a close-up view during surgical procedures.

Radiation therapy

Radiation therapy at the Medical Center includes two rotating machines, one with a cobalt source and the other with cesium. Said to be the world's largest single source in medical use, the cesium is being evaluated for the Atomic Energy Commission as to its applicability in treatment. The radiation therapy unit, housed in underground quarters adjacent to the Main Hospital, treats patients from all over the United States.

Emergency suite

The emergency suite is physically a part of the Outpatient Building and has its own contiguous radiological facilities. The unit houses four emergency operating-treatment rooms in addition to receiving and patient areas.

Banks

The University Hospital is both the depository and the clearing house for the area's tissue banks, which are playing an increasingly important role in medical care. These include skin, eye, blood, and bone banks.

Medical illustration

The Hospital has five medical artists, supervised by a certified medical illustrator, in the Department of Medical Illustration. They provide detailed drawings for teaching purposes and exhibits. The department's photography unit does clinical photog-

— TRAINING PROGRAM CO

To strengthen postgraduate medical training throughout the state, the University of Michigan Medical Center maintains affiliations with 18 hospitals in this and other states. The Center assists these hospitals to establish "independent" approved training programs. Basic science courses are given residents at the community hospitals and clinical experience is provided at the University Hospital in Ann Arbor.

raphy and microphotography, and makes teaching slides and motion pictures.

Radioisotopes

The clinical isotope unit performs studies of radioactive iodine uptake of the thyroid gland, blood volume and red cell volume determinations along with brain tumor localization, radio-iodine therapy of selected cases of hyperthyroidism and thyroid carcinoma. Rotation for residents from a number of services is provided.

The medical library is housed in the five-story Kresge Research

building. Constructed at a cost of \$600,000, the library offers a variety of facilities including a tape-recorded medical abstract service and private cubicles for study and research. The bound volumes in the library total more than 117,000, and over 1,000 current periodicals are received annually.

The library staff is available for consultation and assistance in the preparation of bibliographies. In addition to the medical library, the other schools on the campus maintain their own reference collections, which are also available on call by medical staff.

PROGRAM COMMUNITY HOSPITALS

A unique General Practice program utilizes the resources of Michigan community hospitals having affiliated general practitioners. This two-year program enables the future general practitioner to "independently supervised and directed by experienced colleagues. The candidate spends six months of each year at an affiliated hospital staffed primarily by general practitioners. Aside from its value in training the

young doctor, the program offers valuable postgraduate education to physicians in the local communities.

Following the requirements for American Medical Association approval, the program provides daily bedside teaching, and weekly x-ray conferences, CPC's and clinical conferences. Of the twelve positions available annually, this special program has averaged ten interns per year.



Guest Editorial

Voluntary or Controlled Hospitals?

The voluntary and independent operations of a great part of our hospital system is presently being challenged. Developments in many states throughout the U. S. have led proponents of our present system of hospital and medical care to re-examine roles and responsibilities of all associates. Charges by the insurance commissioner in one state, for example, that "... the medical profession has done practically nothing in the way of curbing abuses in the use of hospital care;" that "doctors are admitting Blue Cross subscribers to hospitals where such care is unnecessary;" that "grounds certainly exist for disciplinary action," lead to the conclusion that the resident physician must concern himself with trends that may affect his future practice and affiliation with hospitals; he must concern himself with the increasing effort by states to provide a measure of control of hospitals.

How do residents in teaching hospitals play an ever increasing role in this new situation? What can the house staff do to increase its effectiveness in countering this economic-born pressure?

Primarily, the house staff member must ally himself

M.D.

When the emotional component of premenstrual tension becomes severe enough to interfere with normal activities and relationships, PROZINE is usually advantageous. It is designed for the treatment of moderate to severe emotional disturbances, either alone or complicated by organic symptoms.

PROZINE acts on both the thalamic and hypothalamic areas of the brain. As a result, PROZINE helps the physician control motor excitability as well as apprehension and agitation. This dual effect permits low dosages, which minimize side-effects and encourage the use of PROZINE in everyday practice.

"This time last month I would have screamed"



PROZINE*

meprobamate and promazine hydrochloride, Wyeth

SPECIFIC CONTROL THROUGH DUAL ACTION



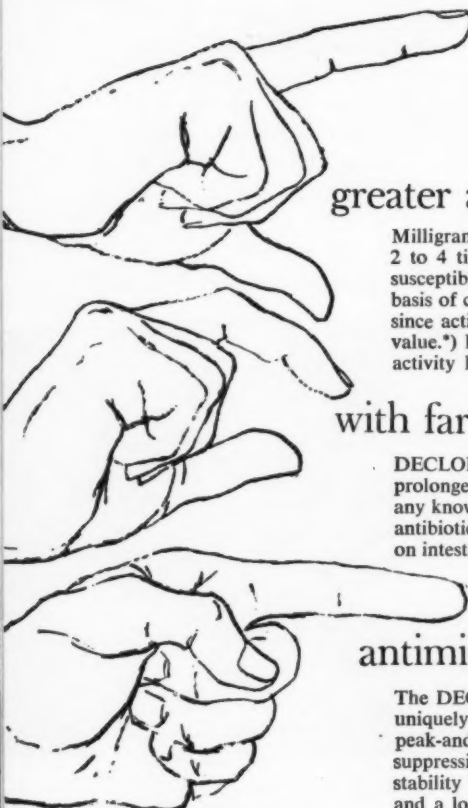
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Philadelphia 1, Pa.

physician

LEDERLE INTRODUCES...

a masterpiece of



greater antibiotic activity

Milligram for Milligram, DECLOMYCIN exhibits 2 to 4 times the activity of tetracycline against susceptible organisms. (*Activity level is the basis of comparison—not quantitative blood levels since action upon pathogens is the ultimate value.**) Provides significantly higher serum activity level...

with far less antibiotic intake

DECLOMYCIN demonstrates the highest ratio of prolonged activity level to daily milligram intake of any known broad-spectrum antibiotic. Reduction of antibiotic intake reduces likelihood of adverse effect on intestinal mucosa or interaction with contents.

unrelenting peak antimicrobial attack


The DECLOMYCIN high activity level is uniquely constant throughout therapy. Eliminates peak-and-valley fluctuation, favoring continuous suppression. Achieved through remarkably greater stability in body fluids, resistance to degradation and a low rate of renal clearance.

*Hirsch, H. A., and Finland, M.: *New England J. Med.* 260:1099 (May 28) 1959.

DECLON

Demethylchlortetracycline Lederle

of antibiotic design



plus
"extra-
day"
activity
FOR
PROTECTION
AGAINST
RELAPSE

DECLOMYCIN maintains activity for one to two days after discontinuance of dosage. Features unusual security against resurgence of primary infection or secondary bacterial invasion—two factors often resembling a "resistance problem"—enhancing the traditional advantages of tetracycline . . . for greater physician-patient benefit

in the distinctive,
dry-filled, duotone
capsule

immediately available as:

DECLOMYCIN
Capsules, 150 mg.
bottles of 16 and 100.

Adult dosage:
1 capsule four
times daily.



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a Division of AMERICAN CYANAMID COMPANY,
Pearl River, New York

OMYCIN



A. C. KERLIKOWSKE
Director
University Hospital
University of
Michigan
Medical Center

with his associates in helping to prevent increases in costs of hospitalization. (They are rising 5 percent annually.) Increasing costs to the hospital means higher premium rates for the health insurance subscriber. With as much as 50 percent of the population of a state affected, the public—even those who personally receive no care—is now aware of hospital costs. Increasing costs have resulted in public proposals for

added controls from the more “Social minded” officials in several states.

In one state, the medical society enumerated the four most frequent forms of “inefficient” use of public voluntary health insurance, particularly Blue Cross:

- Overstay
- Admission for diagnosis only
- Hospitalization as a convenience
- Unnecessary treatments

It is such practices that place hospitals and physicians in a vulnerable position.

Residents in teaching hospitals are particularly involved because it is there that the largest groups of resident staffs are trained and have the opportunity to set examples for their juniors. In the larger hospitals there may be as many as 250 house staff members—not to mention the medical students who are still in the process of formulating their philosophies on medical economics; their thinking will be affected by what they see. Across the country the resident staffs have the power in their institutions to control patient care programs including stays, admissions, tests, and treatments for a sizable number of patients.

Can we in hospital management control cost factors in which you are involved? Indeed, it is complex and difficult in today's economy; and we do not want to pass judgment on related medical prerogatives. Administration has a role in this, of course, but without a competent medical staff, administration and a hospital are both ineffective. Particularly in a teaching hospital today does the resident physician carry a great responsibility for those patients whose care is financed by voluntary hospitalization insurance; he must guard against equating training requirements with long stays and diagnostic tests given without weighed judgment. This is an old story to preceptors and hospital administrators; but the stakes now are high due to public pressure.

The resident physician of today is helping to shape the climate and environment of hospitals for himself as the attending physician of tomorrow. The amount of independence exercised in association with your hospital of the future may depend on your present interest in the economic pressures on our hospital system. The rising clamor of health insurance subscribers and public officials for greater control over hospital operations can increase, bit by bit, to the point of loss of independence for both physician and administrator. This can only be forestalled by all of us as associates. In our respective responsibilities we can contribute our skills and judgment to keep hospital care free from unnecessary costs—costs which make our institutions vulnerable to public charges.

VOLUNTARY HEALTH AGENCY Typically, the voluntary health agency functions as a partnership among physicians, other health profession personnel, non-medical community leaders, and other dedicated lay men and women. Financial support comes from voluntary contributions and bequests by the public. Volunteer physicians, medical scientists, and lay leaders, assisted by full-time

staff,
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from
is an
welfare

**For more than 50 years,
this voluntary agency has
played a major role in our
nation's health progress**

THE AMERICAN HEART ASSOCIATION

George E. Wakerlin, M.D., Ph.D.

Medical Director, American Heart Association

staff, administer and conduct the typical agency program of medical and biological research support, professional and public education, and community services. The nature and proportion of these vary from one agency to another. Basically, the voluntary health agency is an expression of man's sense of individual responsibility for the welfare of his fellow man.

In 1924 the American Heart Association was organized and incorporated as a national body with membership limited to physicians primarily interested in cardiology. During this period, affiliated heart associations were organized in New York City, New England, Philadelphia, and Chicago.

The original aims of the American Heart Association were the gathering, dissemination and application of knowledge concerning cardiovascular function and disease; the encouragement of cardiac clinics; cooperation with other health organizations; and the establishment of local heart associations and committees to implement these objectives.

The professional education activities of the early AHA included an annual scientific meeting, the publication of a scientific journal, and the development of standards for the guidance of the medical profession in relation to cardiovascular disease.

In 1935 a Section on Peripheral Vascular Diseases was formed (which today is the Council on Circulation), thus giving formal recognition to the complementary relationship of the peripheral circulation and cardiology. At the same time membership was broadened to include not only clinics, but anatomists, bio-

chemists, public health workers and surgeons.

Public support

During the late 1930's the physician leaders of the Association concluded that the conquest of cardiovascular disease required the support and participation of the public as well as physicians and scientists. World War II delayed plans for re-organization, but in 1948, with the help of lay leadership, the American Heart Association became a national voluntary health agency similar to the National Tuberculosis Association and the American Cancer Society.*

Lay men and women were welcomed to membership in the American Heart Association and on its Board of Directors as partners in the campaign against heart disease. Soon, substantial nation-wide financial contributions to the Association permitted the expansion of research, education, and community service in the cardiovascular field.

Under the new organization, the Association established scien-

tific councils on community service and education, rheumatic fever and congenital heart disease, clinical cardiology, circulation, and cardiovascular surgery.

In 1950 the American Foundation for High Blood Pressure Research which had functioned as an independent agency for four years, became the Council for High Blood Pressure Research of the Association.

In 1954 the Council on Basic Science was established, and in 1959, the American Society for the Study of Arteriosclerosis affiliated with the Association as its Council on Arteriosclerosis.

Membership

During the past ten years, affiliate heart associations have been organized in all states as well as in Puerto Rico. Membership of the American Heart Association and its affiliate associations is 35,900, of whom 20,500 are physicians, medical scientists and members of other health professions, and 15,400 are laymen.

The budget of the Association has grown from less than \$100,000 before re-organization to more than \$22,000,000 for the year 1958-59. Most of this money is contributed by the public during the Heart Fund Campaign of February.

*In 1948, leaders of the Association played an important role in the establishment by Congress of the National Heart Institute; the Institute and the Association have collaborated closely in their programming ever since.

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New
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Supplie
100 mg
250 mg

Comple
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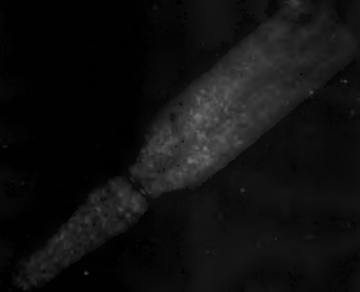
Pfizer

PFIZER

For the first time

CONVENIENCE • ECONOMY

in parenteral Broad-Spectrum antibiotic therapy



TERRAMYCIN®

brand of oxytetracycline

INTRAMUSCULAR SOLUTION

New ready-to-inject ampule form provides economical Broad-Spectrum activity for that all-important first dose.

Supplied: Terramycin Intramuscular Solution*

100 mg./2 cc. ampule

250 mg./2 cc. ampule

*Contains 2% Xylocaine® (lidocaine), trademark of Astra Pharmaceutical Products, Inc.

Complete information on Terramycin Intramuscular Solution is available through your Pfizer Representative or the Medical Department, Pfizer Laboratories.

Pfizer Science for the world's well-being™

PFIZER LABORATORIES, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.

Objective

The primary and ultimate objective of the American Heart Association and its affiliate heart associations is the conquest of cardiovascular disease. The key-stone of the plan to achieve this is the support of biological and medical research to an ever-increasing degree.

Highly important also are the AHA's professional and public education and community service programs which are designed to effect maximum utilization of knowledge already available, but without direct service to patients.

Organization

The AHA is democratically organized with the voice of its professional membership at least equal to its lay membership. Since the program is basically medical and scientific, the Association leans most heavily upon its physician and professional membership for guidance.

Lay membership has predominant responsibility for fund raising, business management, and public relations. However, there is no sharp line between professional and lay members in regard to functions and responsibilities. The basic criterion is the effectiveness of members in furthering the aims of the Association.

Frequently physicians assist in problems of administration and lay volunteers sometimes contribute importantly to medical programming.

Assembly

The most broadly representative body of the American Heart Association is the Assembly which convenes for two days each year at the time of the Annual Meeting.

Through panel sessions, the Assembly discusses policy matters and other problems and makes recommendations affecting Association welfare to the Board of Directors.

The basic importance of the Assembly is indicated by its power to elect the officers and Board of Directors of the Association. The Assembly includes delegates chosen by affiliate heart associations and elected by the scientific councils.

Of Assembly delegates, including officers and Board members, 286 are physicians, medical scientists and other health professionals and 150 are laymen.

Officers, directors

The officers of the Association are a president, president-elect, nine vice-presidents, a secretary and a treasurer. The president,

COMPATIBLE • COORDINATED ANTIBIOTIC THERAPY

TERRAMYCIN®

brand of oxytetracycline

INTRAMUSCULAR SOLUTION

Initiation of therapy in minutes after diagnosis with new, ready-to-inject Terramycin Intramuscular Solution provides maximum, sustained absorption of potent broad-spectrum activity.

The unsurpassed record of clinical effectiveness and safety established for Terramycin is your guide to successful antibiotic therapy.

Supply:

Terramycin Intramuscular Solution*

100 mg./2 cc. ampule

250 mg./2 cc. ampule

Cosa-Terramycin Capsules

125 mg. and 250 mg.

COSA-

TERRAMYCIN®

oxytetracycline with glucosamine¹

CAPSULES

Continuation with oral Cosa-Terramycin every six hours will provide highly effective antibacterial serum and tissue levels for prompt infection control.

Cosa-Terramycin is also available as:

Cosa-Terramycin Oral Suspension

peach flavored, 125 mg./5 cc., 2 oz. bottle

Cosa-Terramycin Pediatric Drops

peach flavored, 5 mg./drop (100 mg./cc.),

10 cc. bottle with calibrated dropper

Complete information on Terramycin Intramuscular Solution and Cosa-Terramycin oral forms is available through your Pfizer Representative or the Medical Department, Pfizer Laboratories.

Pfizer Science for the world's well-being™

PFIZER LABORATORIES, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.

*Contains 2% Xylocaine® (lidocaine), trademark of Astra Pharmaceutical Products, Inc.

president-elect and six of the vice-presidents are physicians or medical scientists. This year the president is Dr. Francis L. Chamberlain of San Francisco and the president-elect, Dr. A. Carlton Ernstene of Cleveland.

The Board of Directors is composed of 117 members elected by the Assembly from the nominees of affiliate heart associations and of the scientific councils. Like the Assembly, the Board is broadly representative of all areas of professional and lay interest in the heart movement. This year there are 67 professional members and 50 lay members on the Board.

The Board is the governing body of the Association and its enactments become the policies and program of the Association, although they are subject to review by the Assembly. The Board elects its chairman who presently is Mr. Bruce Barton of New York City.

Committees

The principal committees of the Board are Nominating, Budget (which scrutinizes and approves the budget), Finance (which determines that money is available for the proposed budget and recommends fiscal policies), Awards, Assembly Planning,

Public Relations, Fund Raising, and Policy.

Physicians or medical scientists are members of all of these committees and are usually chairmen of those which are most concerned with medical and scientific programming, namely, the Nominating, Budget, Awards, and Policy Committees. The officers, Board of Directors and committees are served by Mr. Rome A. Betts, Executive Director and the staff of the General Services Division of the Association, with assistance where necessary from the medical director and the staff of the Medical Division.

From the standpoint of the objectives of the Association, the most important committee reporting to the Board of Directors and its Executive Committee is the Central Committee for Medical and Community Programs. This Committee initiates, guides and reviews medical and community programs of the AHA and affiliates.

The Central Committee is chaired by the immediate past-president of the Association, who this year is Dr. Robert W. Wilkins of Boston.

The Committee is composed of the chairmen of the eight AHA scientific Councils, five chairmen of the principal committees of

the Council on Community Service and Education (the largest and most diversified of the Councils), the chairmen of the four standing committees of the Central Committee, seven members at large and the officers of the Association, *ex officio*.

Under Central Committee supervision, the medical and community programs of the Association are implemented by the four standing committees on Research, Scientific Sessions, Professional Education, and Publications, and by the eight Councils of the Association. The Central Committee and its committees and councils are served by the medical director and staff of the Medical Division.

Research

The Research Committee is composed of twelve members elected by the Central Committee. Each scientific council is represented on the Research Committee and there are five members at large. The term of membership is five years and the terms are staggered. A Research Committee member is ineligible for re-election and may not

serve on the research committee of any other organization during his AHA tenure.

The Research Committee is responsible for the expenditure of more than half of the budget of the National Office and also advises affiliate heart associations in relation to their research programs.

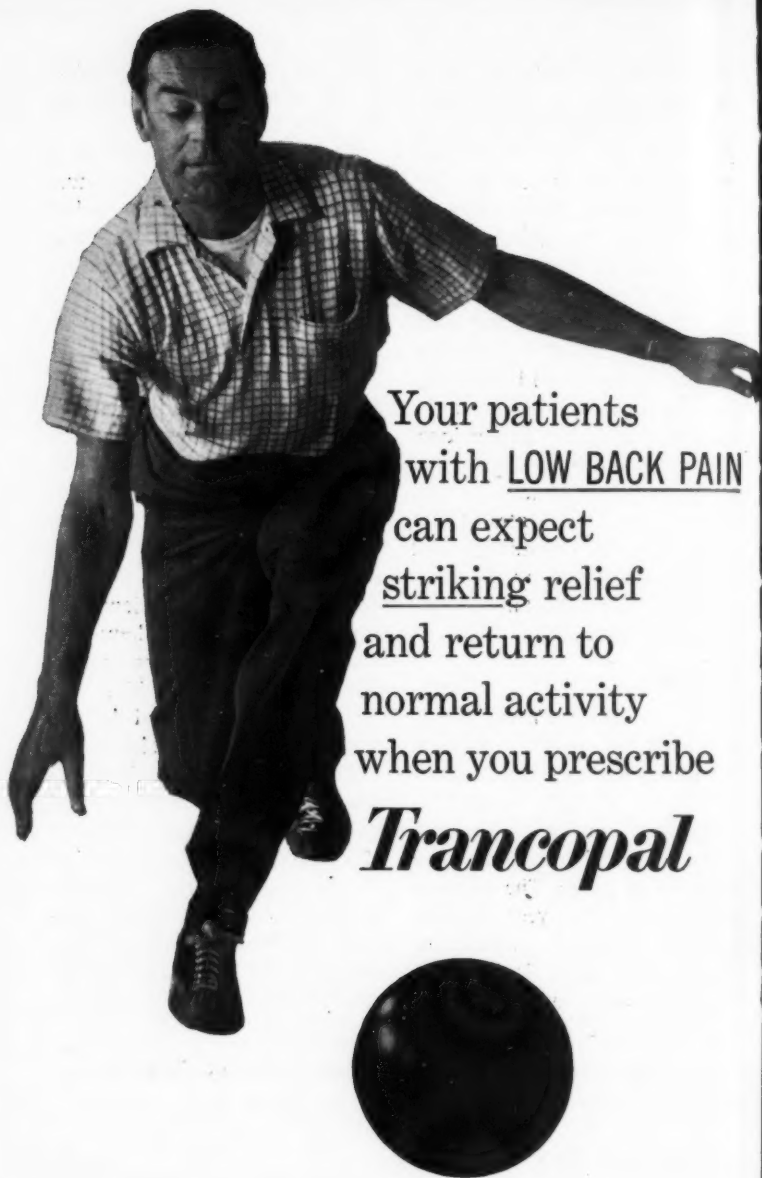
Research support by the AHA and affiliates totaled more than \$8 million this year, of which more than \$3 million was allocated by the National Office and \$5 million by affiliates.

Approximately half of the national research funds support fellowships, which this year included 58 research fellows, 32 advanced research fellows, 83 established investigators, and 6 career investigators. The last category was pioneered by the American Heart Association.

The other half of national research funds is allocated as grants-in-aid, of which there were 236 this year.

One-third of AHA grants-in-aid are for basic research, one-third have basic implications, and one-third are classifiable as applied research.

This article will be concluded in next month's issue.



Your patients
with LOW BACK PAIN
can expect
striking relief
and return to
normal activity
when you prescribe
Trancopal

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case profile.¹ A 42-year-old truck driver and mover injured his back while moving a piano. The pain radiated from the sacral region down to the region of the Achilles tendon on the right side. X-rays for ruptured disc revealed nothing pertinent. The day of the injury he was given Trancopal immediately after the physical examination. Although 100 to 200 mg. three times a day were prescribed, the patient on his own responsibility increased the dosage of Trancopal to 400 mg. three times a day. This dosage was continued for three days and then gradually reduced over a ten day period. During this time, the patient continued to drive his truck. The muscle spasm was completely controlled and no apparent side effects were noted.

For the past six months, the patient has taken Trancopal 100 to 200 mg. as needed for muscle spasm, particularly during strenuous days.

Indications¹⁻⁶ *Musculoskeletal*: Low back pain (lumbago, etc.) / Fibrositis / Neck pain (torticollis) / Ankle sprain, tennis elbow / Bursitis / Rheumatoid arthritis / Myositis / Osteoarthritis / Postoperative muscle spasm / Disc syndrome. *Psychogenic*: Anxiety and tension states / Asthma / Dysmenorrhea / Angina pectoris / Premenstrual tension / Alcoholism.

Now available in two strengths: Trancopal Caplets®, 100 mg. (peach colored, scored), bottles of 100. New strength — Trancopal Caplets, 200 mg. (green colored, scored), bottles of 100.

Dosage: Adults, 100 or 200 mg. orally three or four times daily. Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.

References: 1. Collective Study, Department of Medical Research, Winthrop Laboratories. 2. Lichtman, A. L.: New developments in muscle relaxant therapy, *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958. 3. Lichtman, A. L.: Relief of muscle spasm with a new central muscle relaxant, chlormezanone (Trancopal), Scientific Exhibit, Meeting of the International College of Surgeons, Miami Beach, Fla., Jan. 4-7, 1959. 4. Ganz, S. E.: Clinical evaluation of a new muscle relaxant (chlormethazanone), *J. Indiana M. A.* 52:1134, July, 1959. 5. Mullin, W. G., and Epifano, Leonard: Chlormezanone, a tranquilizing agent with potent skeletal muscle relaxant properties, *Am. Pract. Digest Treat.* 10:1743, Oct., 1959. 6. Shanaphy, J. F.: Chlormezanone (Trancopal) in the treatment of dysmenorrhea; a preliminary report, *Current Therap. Res.* 1:59, Oct., 1959.

THE FIRST TRUE "TRANQUILAXANT" *Trancopal*®

Winthrop LABORATORIES • NEW YORK 18, N. Y.

A GUIDE

for our readers

The conventions of the presentation of advertising material on pharmaceuticals are related to certain ethical and practical considerations. This guide should be of help to all our readers in an understanding of the advertising material contained herein. Unless it is stated to the contrary:

All illustrations of physicians and patients are dramatizations utilizing models and not specific physicians or actual patients. The ethical and other considerations for this are obvious.

Illustrative material such as dummy prescription blanks, hospital charts, calling cards, memos, etc., are presented as dramatizations.

Composite case histories, drawings and/or photomicrographs are often presented to convey typical clinical indications but unless stated to the contrary are constructed as illustrative cases or situations.

Physical limitations of space in journal advertising make the presentation of all relevant data impractical; therefore, it is suggested that for suitable background on dosage indications and contraindications the standard package insert or more extensive background data be consulted.

The acceptance of material for advertising is based upon several criteria; for example, in respect to safety, all new drugs are required to correspond with the accepted Food and Drug application.

It is suggested that any differences of opinion of individual physicians with any advertisements be called to the attention of the editor, with a duplicate copy of the letter to the pharmaceutical house whose advertisement is the subject of the letter.

THE PUBLISHERS

HYPERTENSION

"When chlorothiazide is used, lower and, hence, less toxic dosages of other antihypertensive agents become effective in controlling blood pressure.

Chlorothiazide does not reduce blood pressure in normotensive subjects, although the drug induces the same increase in salt excretion."

Freis, E.D.: J.A.M.A. 188:105, (Jan. 10) 1959.

Dosage: One 250 mg. tablet DIURIL b.i.d. to one 500 mg. tablet DIURIL t.i.d.

DIURIL[®]

CHLOROTHIAZIDE

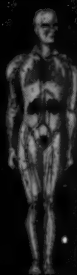
a continuing
and consistently
outstanding record
of safety and
efficacy in:

Supplied: 250 mg. and 500 mg. scored tablets DIURIL (Chlorothiazide). DIURIL is a trademark of Merck & Co., Inc. Additional information is available to the physician on request.

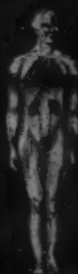


MERCK SHARP & DOHME
Division of Merck & Co., Inc., Philadelphia 1, Pa.

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hypertension



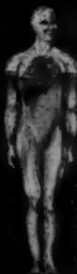
congestive failure



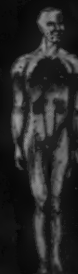
premenstrual tension



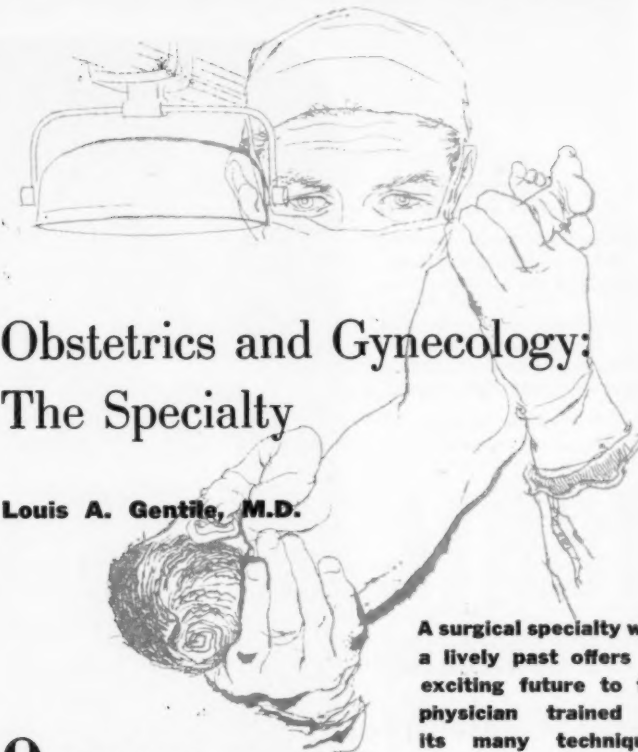
edema of pregnancy



cirrhosis with ascites



renal edema



Obstetrics and Gynecology: The Specialty

Louis A. Gentile, M.D.


A surgical specialty with a lively past offers an exciting future to the physician trained in its many techniques

Obstetrics and gynecology combines the advantages of the referral and non-referral specialty. Many obstetric patients will, of course, be referred, but, as with the general practitioner, many will be referred by other patients.

Although most of the typical practice will be in obstetrics at first, these patients will provide the gynecologic patients which the obstetrician will treat in the

future. Another great advantage is the type of patient. They are usually young, optimistic, and pleasant.

The youth and apparent good health of the patient also has its drawbacks—for seemingly all things in obstetrics should end well. This is not the case, however. A patient with a mild toxemia is admitted and the family



Within 30 minutes,
Pyridium's unusually prompt
analgesic action will
spare needless pain and help
overcome resistance to
urological procedures. When
prescribed for home use,
Pyridium encourages more
normal micturition
by removing the penalties
of pain and burning.

DOSAGE: *Adults:* 2 tablets,
(100 mg. each), three times
daily, before meals.

Children 9 to 12 years:
1 tablet three times daily
before meals.

spare
needless
urinary
pain



PYRIDIUM®
(brand of phenylazo-diamino-pyridine HCl)

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good
as its
y all
d end
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d tox-
family

hysician

*"If a man be brilliant,
let him be a physician;
if clever, a surgeon;
and, if both, an obstetrician."*

reassured. She should respond to treatment; but she does not. The result, a dead baby—possibly the mother too. Explain that to yourself, to the family, to the medical student, who in ignorant bravado is told "obstetrics is just catching babies."

Mistake

If you are looking for high drama, watch a mid-forceps delivery. All the operator can think as he deftly (and sometimes not so deftly) manipulates the forceps is—would a section have been better? Am I damaging the baby? Did I rupture the uterus? Success is taken for granted. There are no small mistakes. In obstetrics every mistake is a catastrophe.

At the midnight meal when everyone is tired and the residents vent their spleen, you hear many enlightening things. The medical residents complain that internal medicine is not a specialty—just high priced G. P.'s treating neurotics all through the day. There

are no esoteric illnesses in practice—and the occasional one is invariably admitted to the charity hospital at the end of expensive and often futile treatment.

Surgeon

The surgeon is not much happier. After a long and arduous residency, doing heroic operations, he has the prospect of those barren years. Those years when he thanks the lord because a bunionectomy or an I & D of a paronychia is referred. The older surgeons refer their failures or terminal carcinoma patients in the hope that youth (and what surgeon who has completed a residency is young) might help them.

Then there are the "narrow and restricted" specialties—anesthesiology, ophthalmology, dermatology, but in these one never knows the whole patient, never really can one be the patient's physician. Or so goes the talk.

Yes, the OB resident is king at the midnight meal. His has been a full day of surgery, medicine and even psychiatry. His future is bright; there are plenty of patients—and soon he will think—too many.

The typical week of the busy obstetrician is usually spent in the following way. Several morn-

arrest
acute
urinary
infection

Pyridium Tri-Sulfa combines the efficacy of the classic triple sulfas with the full analgesic dosage of Pyridium. Relief of pain is prompt—within 30 minutes—and therapeutic sulfonamide levels are obtained within hours.

FORMULA:

Pyridium,* 150.0 mg. (2½ gr.);
(brand of phenylazo-diamino-pyridine HCl)
Sulfadiazine, 167.0 mg. (2½ gr.);
Sulfamerazine, 167.0 mg. (2½ gr.);
Sulfamethazine, 167.0 mg. (2½ gr.).

DOSAGE: Adults: 1 tablet four times daily.



MORRIS PLAINS, N. J.

**PYRIDIUM®
TRI-SULFA**

(phenylazo-trisulfapyrimidine)



ings of the week are used up in elective surgery—the remainder of his mornings at the office and making ward rounds. His afternoons are spent at the office. However he can call no time his own, night or day, for a baby waits for no man. His busy routine has its compensations—for the patients are young and if they are ill, the therapy decisive. Also group practice and partnership arrangements have further lightened the load.

All in all, his week is a busy and interesting one. What really makes an obstetrician's life hectic are the emergencies, ectopic pregnancy, placenta previa, rupture of the uterus, and a host of other catastrophies. In no other specialty is one confronted with so many of these life or death emergencies which demand accurate diagnosis, rapid decision and immediate action.

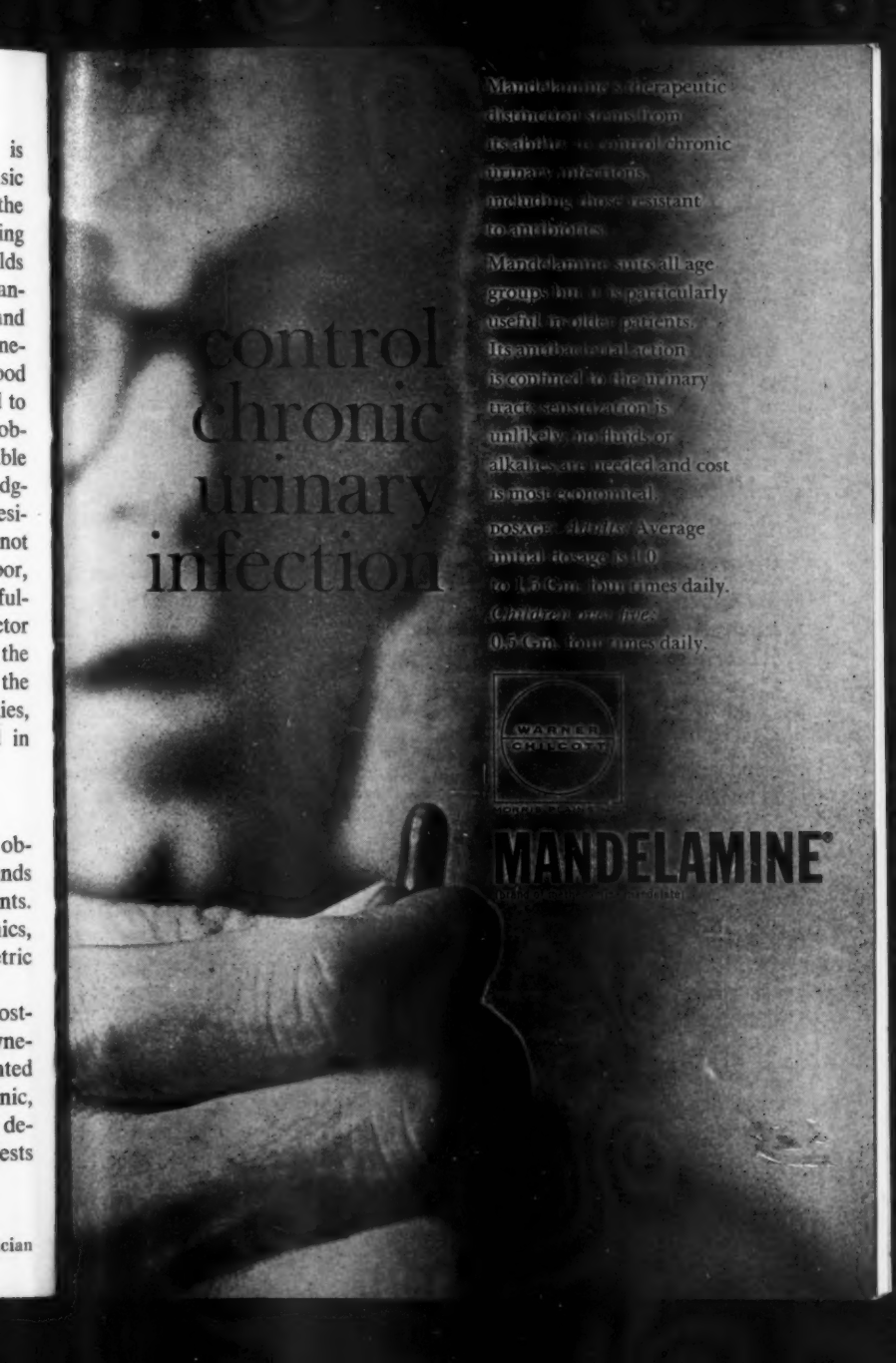
There are 2,600 resident positions in 477 approved programs in the United States today. The minimum time to be spent in residency to be certified is three years or the equivalent. The whole time must be utilized in the treatment of women. In some residency programs, usually a year or two longer, time may be spent doing abdominal surgery, urology, or pathology.

In some residencies there is ample opportunity to do basic work in the laboratory or on the ward. There are many fascinating and unexplored areas in the fields of endocrinology, obstetrical anesthesia, and the medical and psychosomatic treatment of gynecologic disease. However, a good residency is primarily intended to make the doctor a sound obstetrician and a knowledgeable gynecologist, with mature judgment. If after three years in residency the obstetrician is not reverent of the woman in labor, then that residency has not fulfilled its purpose. If a doctor castrates a woman, and at the same time is not aware of all the patient's possible future anxieties, then the residency has failed in its purpose.

Schedule

The typical resident in obstetrics and gynecology spends most of his time with patients. During the day he is in the clinics, often interrupted by an obstetric or gynecologic emergency.

The routine prenatal, postpartum clinics and routine gynecologic clinics are supplemented by an obstetric problem clinic, fertility clinic, or other as determined by the specific interests of the group.



control chronic urinary infection

Mandelamine's therapeutic distinction stems from its ability to control chronic urinary infections, including those resistant to antibiotics.

Mandelamine suits all age groups but it is particularly useful in older patients. Its antibacterial action is confined to the urinary tract; sensitization is unlikely, no fluids or alkalis are needed and cost is most economical.

dosage: *Adults:* Average initial dosage is 1.0 to 1.5 Gm. four times daily.
Children over five: 0.5 Gm. four times daily.



MANDELAMINE®

the trademark name for mandelate

The first year of residency is divided into two halves. Six months are on the obstetric service, learning the diagnosis and treatment of normal and minor obstetric problems, the second half covers the diagnosis and treatment of minor gynecologic problems.

The second year usually emphasizes major obstetric problems and the third year puts emphasis on the surgical treatment of gynecologic disease.

Oldest

Obstetrics is the oldest of the surgical specialties, having its origin in the crude midwifery of the ancient past. It has only been in the last few centuries that the male physician has been privileged to attend at birth. Even more recently has it been freed of the prudery, superstition and reaction which cloaked its early days.

The mother of Hippocrates was a midwife and in the Hippocratic Corpus probably much of what is written on sterility, the anatomy of the genitals, and the process of childbirth was learned from his mother. Although a great deal of the "Corpus" was erroneous—it was a beginning! For now these ideas were written down and could be transmitted,

compared, criticized and enlarged upon. In retrospect, although much was known at this early date, it would be a long way to the obstetric knowledge of the 20th Century.

Soranus of Ephesus (c. 100 A.D.) was the first great gynecologist with many surprisingly modern ideas. He had a fairly good idea of female anatomy but made no mention of the presence of the hymen, an enlightening omission as to the moral condition of the period.

He described the use of cotton and fatty uterine plugs to prevent conception but opposed mechanical abortion. He noted the positions of the uterus. He advised ligature of the umbilical cord, swabbing of the infant's eyes with oil and had many modern ideas on the treatment of the puerpera.

His treatment of threatened abortion does not suffer by comparison with the present-day treatment as can easily be seen by the following: "If, however, the death of the fetus is threatened, in accordance with what we indicated in a previous chapter (and when, as Hippocrates says, the breasts shrink unexpectedly and the thighs, as Diocles says, turn cold), for even if the fetus is in process of separation, one should try to prevent its expul-

In anxiety... tension

when help
is needed to
ease the
apprehensive
mind



BUTISOL[®]


sodium[®]

butobarbital sodium

TABLETS • REPEAT-ACTION TABLETS • ELIXIR • CAPSULES

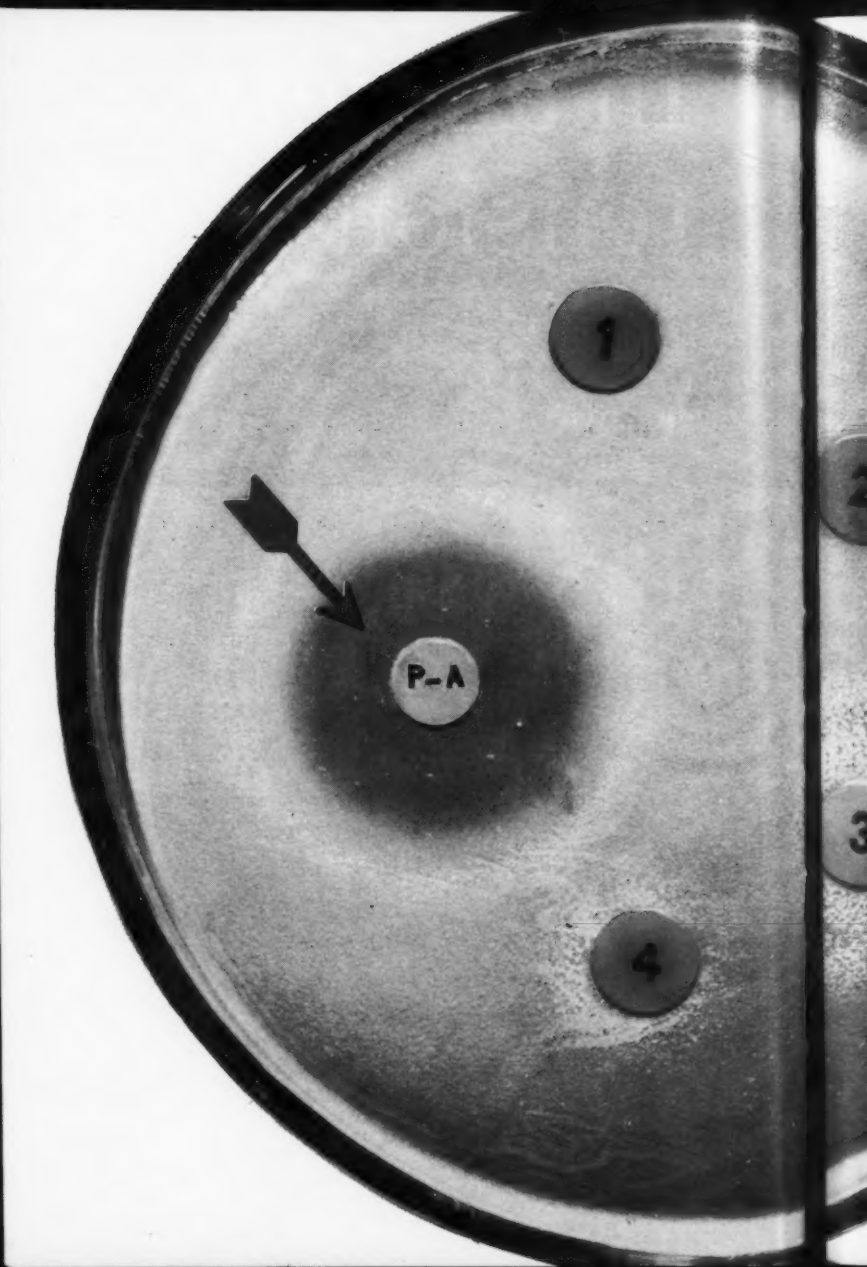
McNEIL LABORATORIES, INC. • PHILADELPHIA 32, PA.

McNEIL



BUTISOL[®] takes the edge off nervousness and tension—without making fundamental changes in a basically healthy personality. A recent comparative study¹ of six widely used drugs for treatment of anxiety and tension in daily practice reveals that Butisol has "the highest therapeutic index" and the "lowest incidence of side effects."

1. Batterman, R. C.; Grossman, A. J.; Mouratoff, G. J., and Leifer, P.; Scientific Exhibit, Annual Meeting of A.M.A., San Francisco, June 23-27, 1958.



This is Panalba performance in pneumonia

... into a mixed culture of the three organisms commonly involved in pneumonia ... *K. pneumoniae*, *Diplococcus pneumoniae*, and *Staphylococcus aureus* (in this case a resistant strain) ... we introduce the five most frequently used antibiotics.

Twenty-four hours later (in this greatly enlarged photograph), note that only *one* of the five leading antibiotics has stopped *all* the organisms, including the resistant staph! This is Panalba.

In your next pneumonia patient ... in *all* your patients with potentially-serious infections ... provide this extra protection with your prescription for

Panalba*

(Panmycin® Phosphate plus Albamycin®)

The broad-spectrum antibiotic of *first resort*

Dosage—1 or 2 capsules 3 or 4 times a day.
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sion. One should order much rest and should put the woman to bed slightly raised, and should apply sea sponges squeezed in diluted vinegar on her pubes and loins. For in this way miscarriage has often been mastered by the use of such treatment in recent separation. But if the embryo is dead, one must assist complete expulsion by means of relaxing agents." (Owsei Temkin's—Soranus' Gynecology).

Writings

In the late middle ages obstetrics was in a sorry state and had retrogressed far beyond the times of Soranus and Paul of Aegina. However, with the Renaissance came a plethora of obstetric literature and the subject of childbirth engrossed all the leading physicians of the time.

"The Byrth of Mankynde," published in 1540, although merely a synthesis of Greek and Latin thought on the subject, achieved an immense popularity. This was one of the first compilations of obstetrical knowledge as a system.

Ambroise Pare was the first great proponent of podalic version and stressed his principles in his writings in 1573. Jacques Guillemeau (1550-1613) in 1609 recommended Cesarean section

on the pregnant woman who had just died. In 1595, Scipione Mercurio stated that contracted pelvis was an indication for Cesarean section. Progress was being made, people were discovering things and writing them down.

Mauriceau

The giant of the obstetric world in the 17th century was Francois Mauriceau (1637-1709) who wrote "*Des Maladies des femmes grosses et de celles qui sont accouchees*" (1668). In this very popular text he describes his study of fetal positions, the uteroplacental circulation and lactation. He demonstrated the conformation of the female pelvis showing that birth could take place without separation of the bones. Strangulation by the umbilical cord was described and he set down a pretty good regimen for the treatment of hemorrhage and placenta previa.

The 18th century was one of great progress for obstetrics. Mascagni, Spallanzani, Santorini, Haller, and Sandifort made great and fundamental contributions to the anatomy and physiology of reproduction. In clinical obstetrics, the French were the unexcelled masters. Nicolas Puzos (1686-1753) advocated bimanual examination of the uterus and

protection of the perineum at delivery.

Andre Livret (1730-1780) and Jean Palfyn (1650-1730) made great contributions in the field of extrauterine pregnancy and placenta previa. J. L. Baudelocque (1746-1810) laid down the principles of parturition and introduced antepartum mensuration of the pelvis.

In England, William Smellie, (1697-1763) both by personal lectures and his "Midwifery" (1752), did much to further the good practice of obstetrics. Although these were the giants, there were countless others in England, France, and elsewhere who were making no small contributions.

Puerperal fever

In the first half of the 19th century, Ignaz Phillip Semmelweis (1818-1865) got to the basis of puerperal fever in "Die Aetiologie, der Begriff und die prophylaxis des Kindbettfiebers". Ironically, Semmelweis died, a broken and disheartened man in an insane asylum from septicemia and meningitis. His ideas were opposed by most of the great physicians in Europe and the United States and it was a long time before his ideas were generally accepted.

Chloroform

Another great figure of this time was Sir James Y. Simpson, who introduced the use of chloroform (1847) into obstetrics. This was done against great opposition but it received general acceptance when Queen Victoria took chloroform in 1853 for the birth of her seventh child.

Section

Also, a landmark in the 18th century was the beginning of gynecologic surgery with the performance of ovariectomy by Ephraim McDowell (1771-1830) who removed an ovarian tumor in Danville, Kentucky. This was done under primitive conditions without anesthesia or asepsis, while the patient sang hymns.

Cesarean section was improved by Max Saenger who introduced the use of sutures and other refinements in 1882. Cesarean section was known hitherto but was used only in hopeless cases. It took its name from the Lex Cesarea which ordered that if a mother died, the infant should be removed immediately through the abdomen.

The progress made is apparent when we note that in London in 1680 one out of forty-four women died in childbirth and today only sixteen in ten thou-

and. Despite these heartening figures, interested physicians are still chopping away at the "irreducible minimum."

The Board

More and more of obstetrics and gynecology is being done by Diplomates of the American Board of Obstetrics and Gynecology. The Board was founded in 1930, consisting of 9 men who were chosen by the American Association of Obstetricians and Gynecologists and abdominal surgeons, the American Gynecological Society and the Section on Obstetrics and Gynecology of the American Medical Association.

The general requirements that follow were abstracted from the Bulletin of the American Board of Obstetrics & Gynecology. The same information can also be found in the Directory of Medical Specialists. For additional information, write:

Robert L. Faulkner, MD,
Secretary
American Board of
Obstetrics & Gynecology
2105 Adelbert Road
Cleveland 6, Ohio

The purpose of the Board is "to encourage the study, improve the practice, and advance the cause of obstetrics and gynecology, subjects which should be

inseparably interwoven; and to grant and to issue to physicians duly licensed by law, certificates or other equivalent recognition of special knowledge in obstetrics and gynecology."

The certificate does not confer a degree, legal qualifications, privileges or license to practice obstetrics and gynecology, nor is its purpose to limit the professional activities of any duly licensed physician who is not certified by this Board. Also, it is not intended by the Board that certification be required as a prerequisite to a hospital staff appointment.

Seven years

An applicant, to be eligible for examination, must establish certain facts. He must be a physician of high moral and professional standing, a graduate of an approved medical school and must have completed an internship or its equivalent. He must also have completed seven years of training and practice after internship to include three years of residency training in clinical obstetrics and gynecology in approved institutions. A suitable preceptorship may be substituted for part of the residency.

An applicant must have two years of post-training practice

limited to obstetrics and gynecology, relinquish all other specialty certificates and must be a full citizen of the United States or Canada.

Certain rulings might be noted at this point. If a candidate intends to specialize in either obstetrics or gynecology, he nevertheless must show a fundamental knowledge of both. It is also recommended that a candidate be well grounded in the basic sciences, the specialties within obstetrics and gynecology and the surgical, medical and psychiatric aspects of the specialty.

Armed services

A candidate who serves in an Armed Service hospital will receive full training credit if the hospital is approved in the specialty. If not, and he serves under a diplomate of the Board or an otherwise qualified obstetrician and gynecologist, he will receive preceptorship credit.

If a candidate fulfills the above criteria, then he makes applica-

tion and pays a fee to admit him to the examination.

The examination consists of two parts. The first part is composed of questions on obstetrics and gynecology and related basic sciences. Also, the candidate must submit 20 obstetric and gynecologic case reports in condensed form.

The second part is made up of an oral examination before three or more examiners to ascertain his familiarity with recent obstetric and gynecologic literature, the related basic sciences, the breadth of his clinical experience, and his general qualifications as a specialist in obstetrics and gynecology. The second part also has a pathology examination where the "candidate is expected to identify pathologic specimens and microscopic sections."

So if you are interested in a dynamic specialty whether as an educator, investigator, or clinician, obstetrics and gynecology offers practically unlimited opportunities.

PHS: Research Programs and the Commissioned Corps

Leroy E. Burney, M.D.

This is the last of three articles describing the many activities of the Public Health Service.

A generation ago, few positions were available for physicians who wanted to devote the major part of their time to research. Today, this situation has changed remarkably. Within the Public Health Service alone, there are a wide variety of positions available to physicians who want to do fulltime research and still provide the security their families need.

As the principal research center of the Public Health Service,

Dr. Burney is Surgeon General, U. S. Public Health Service, Department of Health, Education and Welfare.

the National Institutes of Health at Bethesda, Md., employ a permanent staff of about 7000 persons, including several hundred physicians engaged in laboratory and clinical research, either as PHS Commissioned Officers or as Federal Civil Service personnel. NIH is thus unique not only in size but in its excellent facilities and diversity of programs.

In addition to the permanent staff, there is a constantly fluctuating population of guest scientists, clinical associates, residents, research fellows, consultants, advisors, lecturers, and visitors, representing literally every professional category in the world of clinical medicine and biologically oriented science.

At NIH, extensive laboratory and office buildings are augmented by the Clinical Center, a

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large research hospital permitting direct, sustained integration between basic laboratory research and study of selected patients. The long-term or chronic illnesses are the main focus of research at NIH. These include heart disease, cancer, mental illness,, arthritis and the metabolic disorders, and the neurological and sensory disorders. Other studies are being made of allergy and the infectious diseases, dental and oral diseases, and the aging process in humans.

NIH scientists also test and license biologics used throughout the world in the prevention and treatment of disease. All types of medical research conducted today are represented in the modern laboratories of the National Institutes of Health.

Clinical Center

The clinical dimension of NIH's activities was added in 1953 when the 516-bed Clinical Center received its first patients. To achieve better integration of the many clinical and laboratory disciplines, the clinical programs and certain basic laboratories of the seven major research institutes that comprise NIH share in the use of the Clinical Center facilities.



This arrangement includes a central hospital services organization that assures consistently high standards of patient care and other services needed for patients associated with the clinical research projects of the Institutes. Today, the hospital care program at NIH resembles that of major teaching institutions, with added emphasis on clinical research.

Medical and surgical services are provided by physicians of the Institute in which the patient is under study. The standard hospital services — such as nursing care, dietetics, pharmacy, diagnostic x-ray, routine laboratory tests, rehabilitation, and social services are provided by the Center's staff.

Liaison with referring physicians, medical societies, and hospital accrediting agencies are among other essential activities coordinated or carried out by the Clinical Center staff.

A training program for young physicians, designed to provide unique experience in clinical investigation within the framework of a medical organization devoted exclusively to research, is in effect at the Clinical Center. The program encompasses two major categories of trainees — residents

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Clinical Center
of the National
Institutes
of Health,
Bethesda, Md.

(called clinical fellows) and clinical associates.

Fellows

At NIH the term fellow applies only to those physicians enrolled in a formal residency training program. Such a program might be in the clinical program of one of the Institutes, or in one of the central departments in the Clinical Center. Among the central departments, Board - approved residency programs have been established in clinical pathology, pathological anatomy, and radiology.

In addition to these departments, several of the Institutes have also received specialty board approval. Formal residency programs exist in internal medicine, psychiatry, neurology, and ophthalmology. Appointments to

these residencies are usually reserved for physicians who have obtained one or more years of basic specialty training elsewhere, preferably in an academic environment, and who have demonstrated interest and ability in research.

Associate

The term associate applies to other young physicians with patient care responsibilities at the Clinical Center who are not in a formal training program. Clinical associates are attached to each of the Institutes and, like the residents, become members of the research teams.

Candidates for NIH assignments are generally young physicians and scientists from universities in which there are extensive research programs in the medical

sciences. Many apply upon recommendation of their university preceptors, frequently as a result of conferences between preceptors and NIH scientists.

Physicians interested in these educational opportunities can obtain additional information by writing Dr. Murray C. Brown, Chief, Clinical and Professional Education, Clinical Center, National Institutes of Health, Bethesda, Maryland. Appointments are made two years in advance. Applications for appointment in 1962 will be accepted between March and June of 1960, and candidates will be notified by November.

Research associates

In 1957 another type of opportunity for physicians was developed. Each year about 10 physicians who have finished internship or one year of residency training are appointed to positions in laboratory research. They are carefully matched, after a series of conferences, with a preceptor who is a leading investigator in a field of their interest. Their immediate instruction and supervision is supplemented with 150 hours of planned basic science courses and seminars. Selection is based on

demonstrated potential and interest in basic research. Appointments are made two years in advance.

Rocky Mountain Lab

Established to study and bring under control the spotted fever, which in the early years of this century plagued the Rocky Mountain area, the NIH field station of NIH at Hamilton, Montana, continues to fulfill its responsibilities to the western region of the United States. It is also a world center for research on the rickettsial diseases, including Q Fever, and for work on Colorado Tick Fever and such mosquito-borne diseases as Western Equine Encephalitis.

A number of fungi are also under investigation, including some that thrive in dry climates. Control of these, and indeed many diseases, rests on knowledge of ecology, epidemiology, pathogenesis, and immunology. Basic research is also carried on in the development and field evaluation of vaccines.

The PHS medical officer at the Rocky Mountain Laboratory is not only engaged in professionally rewarding work but also has the recreational opportunities for hunting and winter sports.

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PHS psychiatrist studies activity of emotionally disturbed children at Clinical Center.

Panama Canal

In a cooperative effort with the Army, the Gorgas Memorial Institute, the Central American governments, and other groups, including the World Health Organization, the Public Health Service (through the National Institutes of Health) has assigned physicians, virologists, and other specialists to a Middle America Research Unit (MARU) to study virus and fungal diseases which occur endemically in tropical zones and may occur epidemically in the temperate zones.

MARU provides the PHS specialists with an ideal setting for studying the diseases in their natural setting on a year-round basis.

Communicable disease

The Communicable Disease Center (CDC) at Atlanta, Ga., is a national resource in the fight against communicable disease, serving as a center of specialized knowledge and employing specialists in many fields whose experience is drawn upon by States, communities, national and inter-



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their family

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more than ever



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WHENEVER A DIAPHRAGM IS INDICATED

national organizations, and other groups requiring expert advice and assistance in meeting health problems.

The CDC staff includes physicians, nurses, veterinarians, engineers, scientists, laboratory workers, training officers, and other specialists. Some are commissioned officers and others are civil service personnel.

Disease or disaster anywhere in the United States — an epidemic in Idaho, or a flash flood in Texas — is the alarm that arouses CDC to action. Each team of specialists sent to answer these calls is tailored to fit a particular need. For example, if information reported to CDC suggests an outbreak of infectious hepatitis, medical epidemiologists, clinical pathologists, and sanitary engineers are part of the team. An outbreak of suspected psittacosis would require the services of epidemiologists and public health nurses.

The opportunities for physicians at CDC, therefore, can be found in field study and laboratory investigation of communicable diseases and their control; in demonstration, advisory services, and training; and in epidemic and disaster aid programs. The work of this vital center is diverse and far-flung.

Arctic Center

The arctic regions contain the largest land mass to which the growing population of the earth can expand. In large measure, the population and development of these areas is dependent upon solution of the problems of low-temperature areas which affect health. Ground permanently frozen hundreds of feet deep, extreme temperature, and prolonged periods of light and dark influence the life of plants, animals and man. These areas are characterized by a fauna that is a reservoir of parasites, unfamiliar biotic relationships, and an etiology of important zoonotic diseases that differs from those of temperate climates.

Medical officers and other specialists of the Public Health Service at the Arctic Health Research Center, Anchorage, Alaska, are seeking to expand our knowledge of the health problems of low-temperature areas and to discover new methods for meeting them.

Engineering

The Robert A. Taft Sanitary Engineering Center, Cincinnati, Ohio is a national laboratory for research, specialized technical assistance, and advanced training activities designed specifically for developing new and improved

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methods in the field of environmental sanitation. Its research programs are directed toward techniques in the fields of water supply, water pollution control, sewage and industrial waste disposal, radiological health, air pollution, and milk and food sanitation. The results of this research are made available to professional personnel in state and local health and control agencies responsible for conducting programs in these fields.

For additional information about research assignments in the Public Health Service, write to: Surgeon General, U. S. Public Health Service, Washington 25, D. C. Attention: Division of Personnel.

Public Health Service Commissioned Corps

The Commissioned Corps of the Public Health Service is a professional career organization of medical, health, and related personnel. It is one of the seven uniformed services of this country.

Presidential appointments, a system of regular promotion, agreement to serve wherever the needs of the Service require, rank and tenure comparable to those of the Army, Navy, and Air Force—these and other characteristics

of the Corps have had a proved and continuing appeal to professional people through the years. The pattern of the Corps, as to obligations, pay, and allowances, is similar to that of the Armed Forces.

The Public Health Service has come to be held in high regard by the health and medical professions throughout this country and around the world. The Service's outstanding record of achievement as the health arm of the Government in both peace and war is a tribute to the joint efforts of its commissioned and civil service personnel.

The Commissioned Corps has a Regular and a Reserve component. Officers of the Regular Corps are selected after professional examination and are appointed by the President, by and with the consent of the Senate. Officers of the Reserve Corps are appointed by the Secretary of Health, Education, and Welfare, on behalf of the President. The Corps is directed by the Surgeon General, who is also chief executive of the Public Health Service. The Surgeon General's rank is equivalent to that of the Surgeon General of the Army, Navy, and Air Force.

Appointments in the Regular Corps are made from nation-wide



Team of clinical fellows performs surgery.

competitive examinations and the successful medical candidates are usually commissioned in the grade of Senior Assistant Surgeon, a PHS officer grade equivalent to Navy Lieutenant, Army Captain.

Assignments

Officers on active duty may expect assignments in many parts of the United States and possibly overseas. Where feasible, however, the professional interests and special competencies of both

Regular and Reserve officers are taken into account when assignments are made.

Rotation of medical officers among assignments in the Service follows the principle that the development of a person's professional acumen, and his ability to face situations and make decisions involving many factors, reaches its greatest effectiveness in the person who has had progressively increasing responsibilities in a variety of situations. Among PHS medical officers, professional competency and breadth of experience are increased through a variety of assignments leading to professionally rewarding responsibilities.

Entrance

There are several ways a medical student or young physician may enter the Commissioned Corps:

- Through the Commissioned Officer Student Training and Extern Program (known as CO-STEP), available to second and third year medical students who apply for reserve commissions and active duty during vacation periods.

- Through the medical intern program in Public Health Service hospitals affiliated with major teaching centers. Interns hold

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yl not only curbs the desire
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overcomes the emotional
stresses of dieting

'Dexamyl' Spansule* sustained release capsules control appetite all day long with a single oral dose—between meals as well as at meal-times. Equally important, 'Dexamyl' provides a positive mood improvement that overcomes the stresses, tensions and anxiety usually associated with dietary regimens.

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†T.M. Reg. U.S. Pat. Off. for dextro-amphetamine sulfate, S.K.F.

Reserve commissions equivalent to Navy Lieutenant (j.g.) or Army First Lieutenant and enjoy many of the rights and privileges of other Public Health Service officers on active duty.

- As a general duty medical officer, in the grade of Senior Assistant Surgeon, following one year's internship either at a PHS hospital or at an approved hospital outside the Service.

- As a clinical resident in training at a PHS hospital or the Clinical Center of the National Institutes of Health; or as a public health resident on assignment to a state health department.

Officer program

COSTEP was initiated by the Public Health Service to familiarize undergraduate professional students with activities of the Service. Students are commissioned as Junior Assistant Health Services Officers (Navy Ensign, Army 2nd Lieutenant) and called to active training duty during vacation periods. When the two to four months of active duty are over, their commissions are inactivated, perhaps to be reactivated during another vacation period. Medical students are eligible after two years of professional training.

Applications for COSTEP are

made to the Surgeon General, U.S. Public Health Service, Washington 25, D. C. Attention: RP-Division of Personnel. A special folder on COSTEP is available upon request.

Officer deferment

The Commissioned Officer Residency Deferment (CORD) Program is one method by which the Public Health Service obtains physicians with specialty training, such as psychiatrists, pathologists, radiologists, orthopedic surgeons, general surgeons, and internists. These and others represent a group of specialists for which the Service has a continuing need.

CORD is for candidates who in their intern year may apply for a Public Health Service Commission, requesting deferment from the Selective Service System to continue their training as a resident in a hospital of their choice. This may be done simultaneously with application for appointment as a resident in a specific PHS hospital, or as a clinical fellow or clinical associate at the National Institutes of Health.

If both applications are approved, the applicant is assured that his military obligation will be deferred and that he will be called to active duty to serve

upon satisfactory completion of the residency training period.

Many physicians accept deferment to advance their training and then serve two years with the Service. In some instances, they can arrange for specific assignments by personal conference before accepting a commission. A special folder on the CORD program is available from the PHS upon request.

Requirements

All medical applicants for appointments to the Commissioned Corps must:

- Be citizens of the United States and at least 21 years of age
- Be a graduate or senior student of an accredited medical college
- Be physically qualified
- Submit official transcripts covering undergraduate and professional study. Applicants should have their college or university forward these documents to the Surgeon General; Attention: Division of Personnel

Submitting an application does not obligate an applicant or the Service. Its primary purpose is to enable the Service to evaluate the applicant's qualifications for appointment and to consider assignments in which professional



Radiology: vital adjunct of NIH research.

training and experience can be applied most effectively.

Physicians now holding commissions in the Armed Forces must obtain a release before they can be appointed to the Public Health Service Commissioned Corps.

Draft obligation

Draft registrants can fulfill their Selective Service obligation by serving two years of active duty in the Commissioned Corps. Such active duty satisfies the draft obligation in the same manner as active duty with the Army, Navy,

PAY AND ALLOWANCES

GRADE	Under 2 yrs. service	Over 4 yrs.	RENTAL ²		SUBSISTENCE ³
			Depend- ents	Without Dependents	
Jr. Asst. Health Services Officer (student) .. (Applicable only COSTEP participants)			\$ 85	\$68	\$48
Asst. Surgeon (Intern)		\$370	\$ 94	\$77	\$48
Senior Asst. Surgeon		\$415 ⁴	\$102	\$85	\$48

¹ The four years of medical school are creditable.

² Not subject to Federal Income Tax.

³ Not subject to Federal Income Tax.

⁴ Plus an additional \$100 a month incentive pay, which is increased to \$150 upon completion of two years active duty as a medical officer (includes one year as an intern) in the PHS or in one of the Armed Services prior to appointment in PHS.

and Air Force. Periods of internship or training under certain student programs (such as COSTEP) are not considered part of the two year period of active service required under the Universal Military Training and Service Act. All males under 26 years of age are draft eligible. If they have received a deferment since June 19, 1951, they remain subject to induction until they are 35.

Pay and allowances

Monthly pay and allowances in the entrance grades for medical officers (including medical students in COSTEP), based on cumulative years of service (in-

cluding medical school), are as shown in the table.

The pay table shows that a married intern, with the grade of Assistant Surgeon, currently earns a gross salary of \$6144 a year, and his rental and subsistence allowances are tax free. A senior Assistant Surgeon with dependents, following internship in the Service and one year of active duty as a PHS medical officer, receives nearly \$9000 a year, including tax-free rental and subsistence allowances.

In addition to the special incentive pay described in the footnote to the pay table, PHS medical officers receive automatic length-of-service pay increases

EQUIVALENT GRADES

PHS	NAVY	ARMY OR AIR FORCE
Jr. Asst. Health Services Officer (Student)	Ensign	Second Lieutenant
Assistant Surgeon	Lieutenant (j.g.)	First Lieutenant
Sr. Asst. Surgeon	Lieutenant	Captain
Surgeon	Lieut. Commander	Major
Senior Surgeon	Commander	Lieutenant Colonel
Medical Director	Captain	Colonel
Asst. Surgeon General	Rear Admiral (upper or lower half)	Brigadier or Major General

throughout their career service.* Thus, a medical officer with dependents and 10 years of active duty, holding the grade of Surgeon (Navy Lieutenant Commander, Army Major) currently receives nearly \$12,000 a year. A medical officer in the Director grade, with dependents and 22 years of active duty, currently receives a gross income of over \$17,000 a year.

All officers receive numerous benefits which eliminate certain personal expenses that physicians outside the Corps must bear.

The grades and salaries of Public Health Service medical officers are comparable to those of commissioned officers in the Armed Services, shown in the above chart.

* Prior service as a medical officer in the Armed Forces is credited.

In addition to pay and allowances, Public Health Service officers receive valuable medical benefits for themselves and their dependents, annual leave and sick leave with pay, retirement pay, disability retirement pay, annuities for survivors (plus a 6-month death gratuity up to \$3,000), Social Security benefits for disability, age and survivors.

Retirement pay after 30 years of service is three-fourths of annual base pay at the time of retirement. Regular Corps officers contribute no part of their salaries toward retirement pay.

Additional information about medical careers in the Public Health Service may be obtained by writing to:

The Surgeon General, U. S. Public Health Service, Washington 25, D. C. Attention: Division of Personnel.

What's the Doctor's Name?

Born in Schweisen, Germany, on July 29, 1840, he is said to be a descendant of the biblical editor of the prophecies of Jeremiah.

He emigrated to the U. S. at 15 to avoid conscription into the Prussian Army, settling in Cam-

den, South Carolina. He attended South Carolina Medical College in Charleston and Medical College of Virginia in Richmond. After graduation from medical school, the Civil War in progress, he joined the Third Battalion, South Carolina Infantry, on April 4, 1862, as an Assistant Surgeon.

He was captured twice, at Antietam and Gettysburg, and was imprisoned at Fort McHenry at the War's end. On Nov. 27, 1867, he married Isabel Wolfe. They had three sons. The family moved to New York in 1881.

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He became the first Professor of Hydrotherapy in this country, receiving the appointment at Columbia University. In 1892 he wrote "The Uses of Water in Modern Medicine" and in 1898 "The Principles and Practice of Hydrotherapy." He introduced the Brand treatment of typhoid fever by full baths.

In 1888 he insisted on operation in a case of appendicitis, said to be the first performed in this country. He sponsored free public baths as Chairman of the Committee on Hygiene of the New York County Medical So-

ciety and his crusade led to the opening of the Rivington Street baths in 1901, the first of their kind.

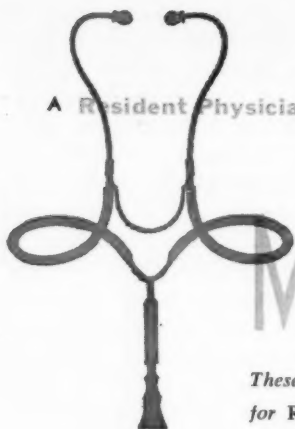
His son Herman, also a physician, became a successful Wall Street financier and American Ambassador to Portugal and Holland. His son Bernard, at 88, millionaire Wall Street financier, philanthropist and benefactor of hospitals and varied charities, is an almost legendary unsalaried statesman and advisor to presidents. He died on June 3, 1921. Can you name this doctor? *Answer on page 171.*

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A Resident Physician MONTHLY FEATURE

Mediquiz

These questions were prepared especially for RESIDENT PHYSICIAN by the Professional Examination Service, a division of the American Public Health Association. Answers will be found on page 171.

1. The etiology of median rhomboid glossitis is:

- A) Rhinoscleroma.
- B) Penicillin Troches.
- ☒ C) Unknown.
- D) Tuberculosis.
- E) Syphilis.

2. The anticoagulant action of heparin can be inhibited by:

- A) Serum.
- B) Prothrombin.
- C) Calcium salts.
- ☒ D) Fibrinogen.
- ☒ E) Protamine.

3. Over one-half of the lesions of tuberculosis of the mouth are

found on the:

- A) Lips.
- B) Gingiva.
- C) Tonsils.
- D) Palate.
- ☒ E) Tongue.

4. Deep-seated pain in the ear and mastoid region, with herpes of the auricle, external auditory canal, and tonsillar region, and often lymphocytosis of the cerebrospinal fluid, indicates inflammation of the:

- A) Trigeminal ganglion.
- B) Ganglion of auerbach.
- ☒ C) Geniculate ganglion.
- D) Gasserian ganglion.

E) Acoustic ganglion.

5. A cyst occurring in a finger at or near the site of a previous crushing or lacerating wound would most likely be diagnosed as:

- A) Dermoid cyst.
- B) Epidermoid cyst. ~~X~~
- C) Retention cyst.
- D) Sebaceous cyst.
- E) Teratoid cyst.

6. In a case of gas gangrene the prognosis is best when the process is confined to the:

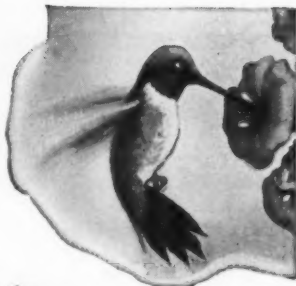
- A) Buttock.
- B) Back.
- C) Leg. ~~X~~
- D) Shoulder.
- E) Thigh.

7. The third plane of the third stage of surgical anesthesia is characterized by:

A) Slow regular respiration, slightly dilated pupils, marked movement of the eyeballs and the presence of corneal reflexes.

B) Irregular thoracic breathing, widely dilated pupils, marked movement of the eyeballs and the presence of corneal reflexes.

C) Weak, shallow respiration, completely dilated pupils, the absence of all reflexes, impalpable radial pulses and low blood pressure.



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D) Normal respiration, normal pupillary size, slight movements of the eyeballs and slight corneal reflexes.

E) Deep abdominal respiration, dilated pupils, absence of eyeball movement and absence of corneal reflexes.

8. The chief danger in the administration of vinyl ether is:

A) Myocardial depression.

B) Anoxia.

✓ C) Liver damage.

✓ D) Explosion.

E) Myocardial irritation.

9. Maintenance of digitalization is difficult with lanatoside C because it:

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A) the gu
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10.
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A) Is poorly absorbed from the gut.

B) Is harmful to veins.

C) Causes excessive nausea and vomiting.

D) Tends to promote arrhythmias.

E) Is rapidly excreted.

10. The most common cardiac disturbance incurred in overdigitalization is:

A) Bigemini.

B) Heart Block.

C) Ventricular tachycardia.

D) Auricular fibrillation.

E) Sinus tachycardia.

11. The peak excretion of fixed base by a patient receiving 10-15 grams of ammonium chloride daily occurs on the:

A) First day.

B) Third day.

C) Fifth day.

D) Eighth day.

E) Fourteenth day.

12. Extension of infection to the tubes by the gonococcus is by way of the:

A) Spermatozoa ascending the genital tract.

B) Blood vessels of the uterus and tubes.

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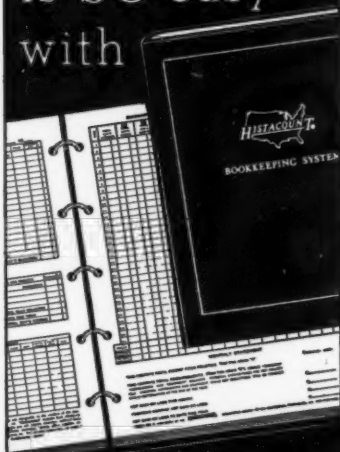
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C) Muscular layers of the wall of the uterus.

☒ D) Mucosal linings of the genital tract. ☐

☒ E) Lymphatics of the vagina or cervix.

13. The operation on the sympathetic nervous system generally used for the relief of vasospastic conditions of the lower extremities consists of:

A) Division of the postganglionic fibers from the lumbar ganglia.

B) Resection of the first to fifth lumbar ganglia.

☒ C) Resection of the second and third lumbar ganglia and the intervening chain.

D) Periarterial sympathectomy.

E) Removal of the lumbar and sacral sympathetic chain.

(Answers on page 171)

PSYCHIATRY

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Rakoff, A.E., in Goldzieher, M.A., and Goldzieher, J.W.: *Endocrine Treatment in General Practice*, New York, Springer Publishing Company, Inc., 1953, chap. 23, p. 345.

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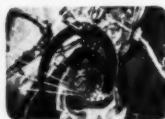
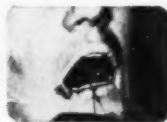
references: (1) Zimmerman, M. C.: Clin. Med. 5:305, 1958. (2) Becker, R. M.: New England J. Med. 254:952 (May 17) 1956. (3) Chen, J. Y. B.; Bard, J. W., and Balisio, A. A., in Welch, H., and Marti-Ibañez, F.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 321. (4) Minno, A. M., and Davis, G. M.: J.A.M.A. 163:222 (Sept. 21) 1957. (5) Zimmerman, M. C., in Welch, H., and Marti-Ibañez, F.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 312.

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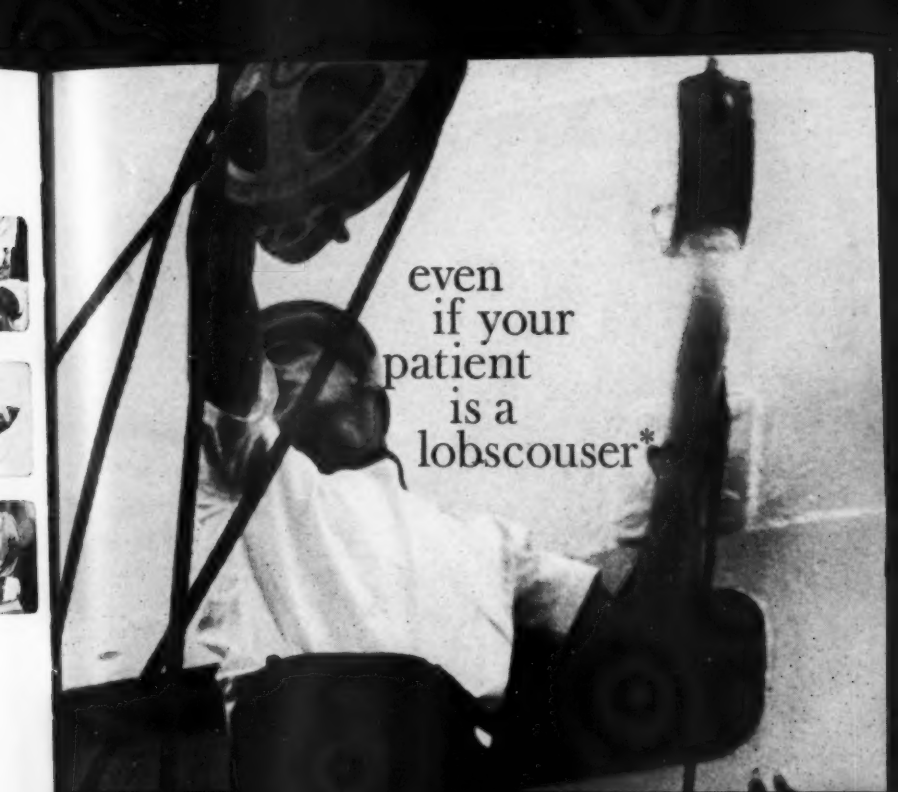
References: 1. Stone, H. H.: Monographs on Therapy 3:1 (May) 1958. 2. Davies, J. I., and Hansen, J. M.: Clin. Res. Notes 2:5 (May) 1959. 3. Stone, H. H.: Clin. Res. Notes 2:3 (May) 1959.



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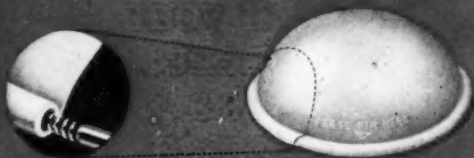
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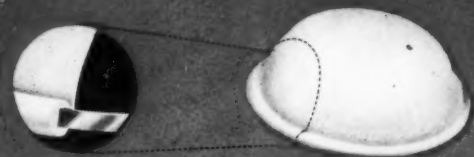
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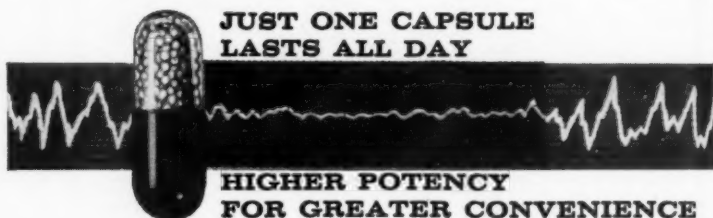


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¹Lennox, W. G., & Markham, C. H.: J.A.M.A. 152:1690, 1953.



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REFERENCES: 1. Gearren, J.B.: *Dis. Nerv. System* 20:66 (Feb.) 1959. 2. Margolis, E.J., et al.: Scientific Exhibit at 12th Clinical Meeting of the American Medical Association, Minneapolis, Dec. 2-5, 1958. 3. Phillips, F.J., and Shoemaker, D.M.: *ibid.* 4. Ayd, F.J., Jr.: *Clin. Med.* 6:387 (Mar.) 1959. 5. Tedeschi, D.H., et al.: in *Trifluoperazine: Clinical and Pharmacological Aspects*, Philadelphia, Lea & Febiger, 1958, pp. 23-33.

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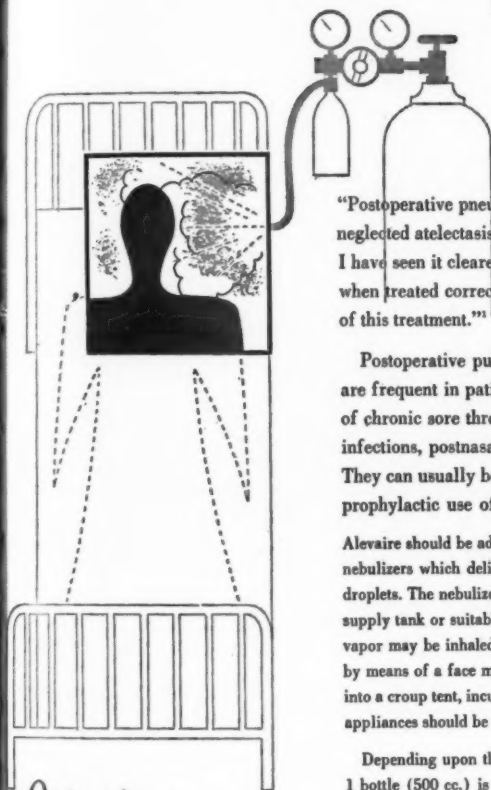
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deliciously flavored • decisively effective

Formula:

Each 5-cc. teaspoonful provides Ilosone Lauryl Sulfate equivalent to 125 mg. erythromycin base activity.

Usual Dosage:

10 to 25 pounds	5 mg. per pound of body weight	} every six hours
25 to 50 pounds	1 teaspoonful	
Over 50 pounds	2 teaspoonfuls	

In more severe infections, these dosages may be doubled.

Supplied:

In bottles of 60 cc.

Ilosone® (propionyl erythromycin ester, Lilly) Ilosone® Lauryl Sulfate (propionyl erythromycin ester lauryl sulfate, Lilly)

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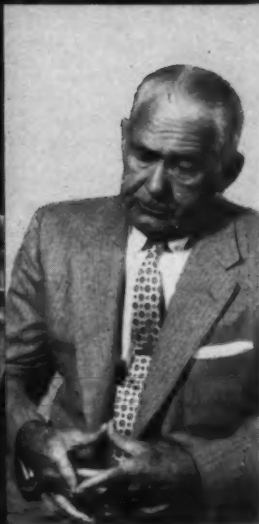
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Jitteriness, apprehension, nervousness and the enervating insomnia which characterize the "anxiety state" encountered in daily practice are easily controlled by small, daytime Butisol[®] dosage.

As shown recently¹ in a prolonged comparative study of routine anxiety patients, Butisol "was found to be the most effective sedative which will produce satisfactory daytime sedation...with minimal occurrence of untoward reactions. Large nighttime hypnotic doses are unnecessary in the majority of patients."²

1. Batterman, R. C.; Grossman, A. J.; Mouratoff, G. J., and Leifer, P.: A Clinical Re-evaluation of Daytime Sedatives, Scientific Exhibit, Annual Meeting of AMA, San Francisco, June 23-27, 1958.

2. Grossman, A. J.; Batterman, R. C., and Leifer, P.: Fed. Proc. 17:373 (March) 1958.

BUTISOL sodium[®] TABLETS • REPEAT-ACTION TABLETS • ELIXIR • CAPSULES

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is more
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can control...

MORE
HIGHLY INDIVIDUALIZED
THERAPY
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RHEUMATIC
"IN-BETWEEN"

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steroids
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Aristo

wider latitude in adjusting dosage

ARISTOGESIC is particularly effective for relief of chronic — but less severe — pain of rheumatic origin. ARISTOGESIC combines the anti-inflammatory effects of ARISTOCORT® Triamcinolone with the analgesic action of salicylamide, a highly potent salicylate. Dosage requirements for ARISTOGESIC are substantially lower than generally required for each agent alone. The exceptionally wide latitude of dosage adjustment with ARISTOGESIC permits well-tolerated therapy for long periods of time with fewer side effects.

Indications: Mild cases of rheumatoid arthritis, tenosynovitis, synovitis, bursitis, mild spondylitis, myositis, fibrositis, neuritis, and certain muscular strains.

Dosage: Average initial dosage: 2 capsules 3 or 4 times daily. Maintenance dosage to be adjusted according to response.

Precautions: All precautions and contraindications traditional to corticosteroid therapy should be observed. The amount of drug used should be carefully adjusted to the lowest dosage which will suppress symptoms. Discontinuance of therapy must be carried out gradually after patients have been on steroids for prolonged periods.

Each ARISTOGESIC Capsule contains:

ARISTOCORT® Triamcinolone	0.5 mg.
Salicylamide	325 mg.
Dried Aluminum Hydroxide Gel	75 mg.
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Supply: Bottles of 100 and 1,000.

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In emergencies, it is the only anticoagulant which acts immediately.

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When you think of anticoagulant therapy, think first of America's first heparin, Liquaemin Sodium...safe, effective, and with convenient dosage forms.



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TERMINAL CANCER

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by mouth • by needle • by rectum

Nearly three decades of use and 500 million administered doses assure a predictable response with DILAUDID: rapid onset, long-lasting analgesia with less euphoria, less drowsiness, less constipation, less nausea and vomiting than morphine. DILAUDID, an opiate, is subject to Federal narcotic regulations, and usual precautions should be observed.

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Specialty My chief is Dr. (full name)

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NIAMID gives the depressed elderly person a new sense of well-being. The family will notice a sunnier outlook, an alert interest in group activities, a renewed awareness of personal appearance, and a return of appetite. Your patient will be more cooperative and less demanding.

You can expect to see the same excellent response to **NIAMID** in a wide variety of depressive syndromes—acute or chronic, mild or severe, whether associated with long-standing or incurable illness, or masquerading as organic disease.

NIAMID side effects are infrequent and mild, and often lessened or eliminated by a reduction in dosage. **NIAMID** has not been reported to cause jaundice, and significant hypotensive effects have rarely been noted.

DOSAGE: Start with 75 mg. daily in single or divided doses, and adjust according to patient response. **NIAMID** acts slowly, without rapid jarring of physical or mental processes. Some patients respond to **NIAMID** within a few days, but for full therapeutic benefit, most require at least two weeks. **NIAMID** is available as 25 mg. (pink) and 100 mg. (orange) scored tablets.

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WHEN THE SYMPTOM IS CYSTITIS

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for rapid control of infection throughout the G. U. system

Rapid bactericidal action against a wide range of gram-positive and gram-negative bacteria including organisms such as staphylococci, *Proteus* and certain strains of *Pseudomonas*, resistant to other agents ■ actively excreted by the tubule cells in addition to glomerular filtration ■ negligible development of bacterial resistance after 7 years of extensive clinical use ■ excellent tolerance—nontoxic to kidneys, liver and blood-forming organs ■ safe for long-term administration

AVERAGE FURADANTIN ADULT DOSAGE: 100 mg. q.i.d. with meals and with food or milk on retiring. Supplied: Tablets, 50 and 100 mg.; Oral Suspension, 25 mg. per 5 cc. tsp.

REFERENCES: 1. Editorial: J.M.A. Georgia 46:433, 1957. 2. Colby, F. H.: Essential Urology, Baltimore: The Williams & Wilkins Co., 1953, p. 330.

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An important step in assuring the vitamin potency of Vi-Sol drops is this aquameter check for excessive moisture. This precision instrument makes it possible to determine moisture content to an exact degree, an extra measure of care that is routine with each lot of Vi-Sol drops.

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This test for moisture level is just one of the many conducted, using the most advanced equipment, that make certain of stated *potency* at the time of manufacture. Other tests are designed to assure vitamin *stability* throughout shelf-life and use.

This meticulous care at every step makes *the big difference* in Vi-Sol drops. The mother knows that the product is pure and safe... the formulation sound and the potency stable when she sees the Mead Johnson name on the label.

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rate of absorption faster than menadione or derivatives...more potent and lasting effects.

substantially safer than vitamin-K analogues—no kernicterus reported.

capsules for oral use...fine aqueous dispersion for parenteral administration.

unlike vitamin-K analogues or similar products, the parenteral form of Konakion is a fine aqueous dispersion compatible with most I.V. vehicles.

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PHYSICIANS NEEDED TO WORK WITH psychiatric patients in 2400-bed hospital. Salary range \$6505 to \$13,970, depending upon qualifications, 15% additional if Board certified (not to exceed \$16,000). Approved three-year psychiatric residency collaborating with Northwestern University. Citizenship required. Write Manager, VA Hospital, Downey, (near Waukegan), Illinois.

INTERNISTS WANTED: 837-bed General Hospital with 320 medical beds. Have opening for board certified or board eligible Hematologist, Neurologist and General Internists. Write Box 902, c/o Resident Physician, 1447 Northern Boulevard, Manhasset, N. Y.

PEDIATRICIAN — Board qualified or Board certified, for permanent position in all-purpose medical group. Contact Dr. C. B. Esselstyn, Rip Van Winkle Clinic, Hudson, New York.

ANESTHESIOLOGIST—WOMAN, for private practice in 150 bed general hospital. Board certified or Board qualified for Staff appointment. Write to Dr. Esther Bartlett, New England Hospital, Boston 19, Massachusetts.

ORTHOPEDIC SURGEON WANTED. Well-established expanding 20-man group located in excellent hospital. Board eligible or certified. Good salary for 2 years with opportunity for group partnership, or excellent transition from residency to private practice. Write Box 121R c/o Resident Physician, 1447 Northern Boulevard, Manhasset, New York.

WANTED: ORTHOPEDIC SURGEON, Board eligible, as Associate interested in eventual partnership in suburban area of greater New York. Attractive starting salary; write Victor H. Raisman, M.D., 120-12 84th Avenue, Kew Gardens 15, New York.

PHYSICIAN FOR A 1700-BED PROGRESSIVE Neuropsychiatric Hospital—Salary \$9890 to \$12,770; extra allowance of 15% if Board Certified. Write: Manager, Veterans Administration Hospital, Danville, Illinois.

UNUSUALLY ATTRACTIVE OPPORTUNITY for well trained ophthalmologist who is board certified or board eligible. Up to \$25,000, the first year and possibility for partnership at the end of that period. Write Box 92R, Resident Physician, 1447 Northern Boulevard, Manhasset, New York.

ASSOCIATE WANTED—Excellent opportunity to associate with Internist. Full equipment; 15 miles New York City. Excellent community. Must be married; two or three years of medical residency. American school graduate. To start July 1, 1960. Send complete biography. Write Box 1259R, Resident Physician, 1447 Northern Boulevard, Manhasset, New York.

ORTHOPEDIST WANTED. Unusually attractive opportunities for certified or board qualified Orthopedist for large Southeastern city, rapidly growing community, new office building with Medical Center facilities. Write Box 5912R, Resident Physician, 1447 Northern Boulevard, Manhasset, New York.

WANTED—GENERAL PRACTITIONER: six-man group; in beautiful Black Hills; office and car furnished; \$12,000, with fringe benefits; immediate opening. Write: Homestake Hospital, Box 877, Lead, South Dakota.

OPHTHALMOLOGIST WANTED. Established expanding 20-man group located in excellent hospital. Board eligible or certified. Good salary for 2 years with opportunity for group partnership, or excellent transition from residency to private practice. Write box 1059, c/o Resident Physician, 1447 Northern Boulevard, Manhasset, New York.

OB-GYN.—SOUTHWESTERN MICHIGAN Resort Area: town 35,000, shopping area 100,000. Established 10 years, gross to \$40,000, two approved hospitals 4 and 8 minutes. Buy lease of air-conditioned office, general office equipment and records; medical equipment optional. Will introduce duration desired. Liberal terms. Reply to Box 112R, Resident Physician, 1447 Northern Boulevard, Manhasset, New York.

INTERNIST WANTED—Board eligible or certified as colleague in established 6-man department of 20-man specialty group in excellent hospital association. Salary \$14,000 first year, \$16,000 second year, then partnership. Furnish complete autobiography in initial reply. Write Box 113R, c/o Resident Physician, 1447 Northern Boulevard, Manhasset, New York.

RESIDENTS WANTED

APPROVED INTERNSHIPS—Rotating, twelve available July 1, 1960, in 222-bed modern general hospital; also approved residencies in Internal Medicine, Obstetrics-Gynecology and Pathology. Approval pending in General Surgery, Radiology, and Anesthesiology after a recent survey by A.M.A. Stipend, \$225 per month plus full maintenance for interns; \$250-\$300 per month for residents. Opportunity to work with Board men in all specialties. Apply: Director of Medical Education, St. Francis Hospital, Honolulu 17, Hawaii.

RESIDENCIES, MENNINGER SCHOOL of Psychiatry. Approved three year program—balanced clinical and didactic training including psychotherapy and somatic therapies, outpatient and child psychiatry; at VA. State and Menninger Hospitals; affiliated with Topeka Institute for Psychoanalysis. Five year appointments combining residency and staff experience for Board eligibility available at staff salaries. Write: Registrar, Menninger School of Psychiatry, Topeka, Kansas.

IOWA CITY — PSYCHIATRIC RESIDENCIES: Department of Psychiatry, University of Iowa Medical Center; three year approved training; broad experience with adults and children; community services, inpatient and outpatient training and all types of psychiatric therapy under close supervision; Master of Science program for residents interested in academic and research careers; salary levels \$3600 to \$4200; also available "package plan" covering five years with periods of rotation in the Department of Psychiatry and the state mental hospitals and schools for mentally defective; salary levels \$6750 to \$9150. For information and application blanks write: Paul E. Huston, MD, Chairman, Department of Psychiatry, 500 Newton Road, Iowa City, Iowa.

WANTED: RESIDENT PHYSICIAN, age 28 to 35, Northern California County Hospital. Modern well-equipped ninety bed hospital, fifty additional beds under construction. Consulting staff of board specialists in all major fields. Unfurnished six room house on hospital grounds. California license required. Salary \$10,860, per year, plus house and utilities. Write Vonnie Dunston, M.D., Medical Director, Box 639, Redding, California.

PSYCHIATRIC RESIDENCIES, New York City —1000-bed University teaching hospital. Full didactic program. Three year accreditation. Eclectic orientation. Faculty of State University School of Medicine in regular attendance as Consultants. Affiliation with another hospital and clinics for enrichment and diversity of case material. Priority consideration for admission to Affiliated Psychoanalytic Institute. Salary range: \$3250 to \$4165; \$6505 to \$9890 for career residents. Apply—Director of Professional Services, Veterans Administration Hospital, Brooklyn 9, New York.

THREE-YEAR APPROVED RESIDENCY in Internal Medicine, 480-bed university affiliated, teaching medical service, including female medicine, subspecialties, research, isotopes, supervised by full-time certified internists. Citizenship or graduation from U. S. or Canadian Medical School required. Contact: Dr. Grosvenor W. Bissel, Chief, Medical Service, Veterans Administration Hospital, Buffalo 15, New York.

PATHOLOGY RESIDENCY, 1st or 2nd year appointments available July 1, 1960; \$3780-\$4020 and maintenance plus opportunity for extra income; full four-year approval. Surgicals 8000; autopsies 320; total exams 300,000. Contact John W. Howard, M.D., Pathologist, Delaware Hospital, 14th and Washington Streets, Wilmington, Delaware.

WANTED, ONE SECOND YEAR SURGICAL resident, October 1959, one first year resident January, 1960 and two July, 1960, for accredited three year program, 190-bed teaching hospital. Starting salary \$5400, if married. Foreign graduates will not be considered without ECFMG certificates. Write W. H. Potter, M.D., Harlan Memorial Hospital, Harlan, Kentucky.

RESIDENCIES IN PSYCHIATRY—Duke University Medical Center; three year approved; complete patient and research facilities; closely supervised, analytically oriented psychotherapy and somatic therapy, adult and children's OPD; training in psychosomatic medicine and neurology; minimum starting salary \$3000; plus room and board, uniforms and other financial aid. Write: Dr. Ewald W. Busse, Chairman, Department of Psychiatry, Duke University, Durham, North Carolina.

PSYCHIATRIC RESIDENCIES at the Philadelphia Psychiatric Hospital. Fully approved by AMA, AHA, ACS, for three years' training in Psychiatry as preparation for Boards. A 150-bed inpatient service treating acute psychotic and psychoneurotic patients. Active outpatient service treating mainly neurotic patients in intensive psychotherapy. Training is psychoanalytically-oriented and psychotherapy cases are supervised beginning in the first year. Affiliation for neurology, child psychiatry and psychosomatic medicine. Personal psychoanalysis is encouraged; time can be arranged. Applications now being accepted for training year beginning July 1, 1960. Address communications to Samuel Cohen, M.D., Medical Director, Ford Road and Monument Avenue, Philadelphia 31, Pennsylvania.

NEW YORK CITY—RESIDENTS. A psychiatric service in a general hospital with approved three year training program. All paramedical services fully operative. Located in the Greenwich Village section of New York City. Physical plant modern, up-to-date, recently constructed. This general hospital consists of 830 beds covering all specialties, and including a current capacity of 82 beds in a Psychiatric Pavilion. Affiliated with New York University-Bellevue Medical Center. Residencies available at 1st and 3rd year levels. For further information write the Administrator, St. Vincent's Hospital of the City of New York, 153 W. 11th St., New York 11. Applications now being accepted for training starting July 1, 1960.

PATHOLOGY RESIDENCY—4 years for 6 residents. Fully approved for PA and CP. Four Certified Pathologists. Surgicals — 9000; autopsies—325; total exams.—688,863. Indiana University teaching conferences and appointments available. Stipend first year \$3336 with opportunity for extra income and annual increases. Housing on premises available. Indiana licensure is necessary. Apply to Dr. Lester H. Hoyt, Director of Laboratories, Methodist Hospital, Indianapolis 7, Indiana.

AVAILABLE JULY 1, 1959, APPROVED pathology residency in large general hospital. Contact Medical Director, San Joaquin General Hospital, French Camp, California, for details.

APPROVED RESIDENCIES IN MEDICINE in Cancer Research Hospital. Excellent facilities for clinical training. Participate in research in Hematology, Endocrinology, Metabolism, Cancer Chemotherapy. Internship, one prior year medical residency in U.S.A. and interview required. Salary, \$4010-\$4570. Write, chairman, Medical Residency Committee, Roswell Park Memorial Institute, Buffalo, New York.

RESIDENCIES IN PSYCHIATRY—University of Oklahoma Medical Center. Three year approved training provides broad experience in dynamic psychiatry with intensive psychotherapy of inpatients and outpatients; physiological and pharmacological therapies; neurology; child psychiatry; social and preventive psychiatry; behavioral sciences; psychoanalysis; psychosomatic medicine. Residents participate in research and teaching. Optimal supervision, excellent case material, complete curriculum. Stipends: first year \$4500; second year \$5000; third year \$5500. Applications now being considered for residencies beginning July 1960. For details write: Louis Jolyon West, M.D., Professor of Psychiatry, University of Oklahoma Medical Center, 800 Northeast 13th Street, Oklahoma City 4, Oklahoma.

RESIDENCIES — INTERNAL MEDICINE and General Surgery, fully approved; 377-bed GM&S Veterans Administration Hospital, affiliated with the Johns Hopkins and University of Maryland Medical Schools; salary \$3250-4945, U.S.A. citizenship required. Address inquiries to Director, Professional Services, Veterans Administration Hospital, Fort Howard, Maryland.

PROCTOLOGY RESIDENCY — Immediately available; 2-year approval; 500-bed general hospital; personal interview desirable. Apply Orlando M. Bowen, Administrator, Allentown Hospital, Allentown, Pennsylvania.

PSYCHIATRIC RESIDENCIES—Buffalo, N. Y. Edward J. Meyer Memorial Hospital—University of Buffalo School of Medicine—now considering applications for psychiatric residencies beginning July, 1960. Full 3 year approved training in a 136 bed division of a general hospital providing comprehensive training in analytically oriented dynamic psychiatry, somatic and drug therapies, neurology, child psychiatry, psychosomatic medicine, forensic psychiatry as well as individual supervision. Residents are given teaching and research opportunities. Salary: \$3875 1st year, \$4575 second year, \$5275 third year plus meals and laundry. Write to: Dr. S. Mouchly Small, Professor of Psychiatry, 462 Grider Street, Buffalo 15, New York.

KANSAS—RESIDENCIES & FELLOWSHIPS in Psychiatry. Three year approved program, all at Kansas University Medical Center. Sixty-five inpatient beds attached to general hospital of five hundred beds. Active outpatient department, training in child psychiatry, psychosomatic medicine. Total of twelve residents in highly individual program with emphasis on dynamic psychotherapy. To appoint five first year residents July 1, 1960. Salary range adequate. For information write: Dr. Donald C. Greaves, Professor of Psychiatry and Chairman of the Department, University of Kansas Medical Center, Kansas City 12, Kansas.

PEDIATRIC RESIDENCY—Position open July 1 for two year fully approved program in 500-bed charity hospital. Excellent teaching program by Board certified pediatricians of the visiting staff. Occupying new well equipped hospital January, 1960. Rapidly growing community. \$260 per month plus maintenance. Contact medical director, Santa Clara County Hospital, San Jose, California.

GENERAL PRACTICE RESIDENCIES available in six state general hospitals. Patient population is 100 percent charity offering a wide variety and large number of cases. Supervision by L.S.U. and Tulane School of Medicine. No interns and first or second year residents to compete with. Hospitals located in larger urban centers with good schools and recreational facilities. Pay \$375 to \$400 per month. Only U.S. and Canadian Medical School graduates are eligible. Contact Director of Training, State Department of Hospitals, State Capitol Building, Baton Rouge, Louisiana.

VACANCIES JULY 1960 FOR RESIDENTS in Internal Medicine (1st, 2nd, and 3rd year), General Surgery (1st, 2nd, 3rd, and 4th year), Radiology, PM&R, and Pathology. Large hospital. Excellent material. Write Box 160R, c/o Resident Physician, 147 Northern Boulevard, Manhasset, New York.

CALIFORNIA—INTERNAL MEDICINE, 1500-bed general hospital, 3 year approval, affiliated with medical schools of University of Southern California, College of Medical Evangelists, and University of California at Los Angeles; includes all subspecialties under supervision of Board Certified specialists. Graduates of U. S. or Canadian medical schools only. Appointments available January and July, 1960. Write, Director, Professional Services, VA Hospital, Long Beach, California.

APPROVED RESIDENCY IN PATHOLOGY in Cancer Research Hospital, specializing in oncologic pathology. Responsibility and training in tumor diagnosis. Individual research encouraged. Salary \$4010 to \$4570. Available July, 1960. Apply John W. Pickren, M.D., Roswell Park Memorial Inst., 666 Elm Street, Buffalo, N. Y.

RESIDENCIES IN PSYCHIATRY available at Veterans Administration Hospital, Brockton, Massachusetts; approved for three-year psychiatric residency training. The comprehensive program of dynamically oriented psychiatry includes hospital psychiatry, mental hygiene clinic experience, neurology, and child psychiatry. Residency under supervision of Deans Subcommittee for Neuropsychiatry of Boston University, Harvard and Tufts Medical Schools. Graduates of approved U. S. or Canadian Medical Schools eligible. Apply to Director, Professional Services, VA Hospital, Brockton, Mass.

STAFF PSYCHIATRISTS AND RESIDENTS—

Gracie Square Hospital, a new 232-bed private psychiatric hospital in Midtown Manhattan has complete psychiatric, medical and surgical facilities for active treatment of all psychiatric disorders; approval of psychiatric residency training program is pending and accreditation will be retroactive; appointments immediately available; resident's salary \$4000 to \$6000. No exchange visitors. Write: Leonard Cammer, M.D., Director, 420 East 76th Street, New York 21, New York.

RESIDENCIES AVAILABLE: Modernly equipped 516 bed GM&S, fully approved VA Research Hospital; affiliated with Northwestern University Medical School; openings for residents in internal medicine, general surgery, pathology, physical medicine and rehabilitation, diagnostic and therapeutic radiology, neuropsychiatry, available July 1, 1960. Must be citizens and graduates of approved schools. Stipend \$3250-5545. For information write: Director, Professional Services, VA Research Hospital, 333 E. Huron St., Chicago 11, Illinois.

PHYSICAL MEDICINE RESIDENCIES: Approved residency immediately available in a large teaching and research Department of Physical Medicine and Rehabilitation. A great variety of acute and chronic patients including paraplegia and blind rehabilitation. Intensive training available in EDK and EMG. Salary levels up to \$9890 per year depending upon qualifications. Apply to Director of Profession Services, Veterans Administration Hospital, Hines, Illinois.

THE UNIVERSITY OF TEXAS—M.D. ANDERSON Hospital and Tumor Institute and The Postgraduate School of Medicine are presently considering applications for Residency Training and Fellowship Awards in 14 Clinical and 10 Basic Science fields as pertains to malignant disease. Your inquiry is invited. Information is available upon request by writing to the Office of Education, M.D. Anderson Hospital and Tumor Institute, Texas Medical Center, Houston 25, Texas.

PSYCHIATRY RESIDENCIES — Southwestern Medical School—Parkland Memorial Hospital 3 year approval; program features inpatient, outpatient, psychosomatic and child experiences in teaching and research setting; special general practitioner fellowships are available. Direct inquiries to: R. L. Stubblefield, M.D., Medical School, 5323 Harry Hines Boulevard, Dallas, Texas.

ONE GENERAL PRACTICE RESIDENCY open December 15, 1959, to replace doctor entering service. Salary \$700 per month; housing furnished. Paid vacation and excellent working conditions. This is excellent training for someone who is planning on going into general practice. Kings County General Hospital, Hanford, California.

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VIEWBOX DIAGNOSIS

(from page 23)

Intussuscepting Lipoma in the transverse colon. Notice the widening of the transverse colon by a radio-lucent mass.

MEDIQUIZ ANSWERS

(from page 160)

1 (C), 2 (E), 3 (E), 4 (C), 5 (B),
6 (C), 7 (E), 8 (C), 9 (E), 10 (A),
11 (B), 12 (D), 13 (C)

WHAT'S THE DOCTOR'S NAME?

(answer from page 158)

SIMON BARUCH

RESIDENT RELAXER

(puzzle on page 27)

P	A	S	T	A	R	A	S	P	T	A	B	U	
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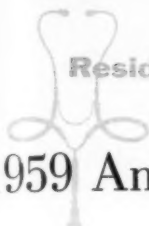
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Resident

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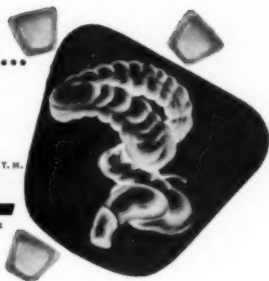
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1. Macy, I. G.; Kelly, H. J., and Sloan, R. E.; with the Consultation of the Committee on Maternal and Child Feeding of the Food and Nutrition Board, National Research Council: *The Composition of Milks*, National Academy of Sciences, National Research Council, Publication 254, Revised 1952. 2. Research Laboratories, Mead Johnson & Company.



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